DOCKET

No. 09-38

Title:	Health Care Service Corporation, Petitioner v. Juli A. Pollitt, et al.
Docketed:	July 10, 2009
Lower Ct:	United States Court of Appeals for the Seventh Circuit
Case Nos.:	(08-3509)
Decision Date:	March 10, 2009
Rehearing Denied:	April 8, 2009

Questions Presented

~~Date~~~	~~~~~~~~Proceedings and Orders~~~~~~~~~~~~~~~~~~~~~~
Jul 7 2009	Petition for a writ of certiorari filed. (Response due August 10, 2009)
Aug 7 2009	Brief of respondents Juli A. Pollitt and Michael A. Nash in opposition filed.
Aug 18 2009	Reply of petitioner Health Care Service Corporation filed. (Distributed)
Aug 19 2009	DISTRIBUTED for Conference of September 29, 2009.
Oct 5 2009	DISTRIBUTED for Conference of October 9, 2009.
Oct 13 2009	Petition GRANTED.
Nov 20 2009	The time within which to file the joint appendix and petitioner's brief on the merits is extended to and including December 11, 2009.
Nov 20 2009	The time within which to file respondents' brief on the merits is extended to and including January 25, 2010.
Nov 30 2009	SET FOR ARGUMENT ON Wednesday, March 3, 2010.
Dec 11 2009	Joint appendix filed. (Statement of costs received.)
Dec 11 2009	Brief of petitioner Health Care Service Corporation filed.
Dec 11 2009	Consent to the filing of amicus briefs, in support of either party or of neither party, received from counsel for the respondents.
Dec 14 2009	Consent to the filing of amicus briefs, in support of either party or of neither party, received from counsel for the petitioner.
Dec 18 2009	Brief amici curiae of Association of Federal Health Organizations, et al. filed.
Dec 18 2009	Brief amicus curiae of Alliance of Community Health Plans filed.
Dec 18 2009	Brief amicus curiae of Aetna Inc. filed.
Dec 26 2009	CIRCULATED.
Jan 5 2010	Record for U.S.C.A. for 7th Circuit is electronic.
Jan 12 2010	Record received from U.S.D.C. for Northern District of Illinois. (1 envelope)
Jan 25 2010	Brief of respondents Juli A. Pollitt, et al. filed. (Distributed)
Feb 1 2010	Brief amicus curiae of United States filed. (Distributed)
Feb 1 2010	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
Feb 19 2010	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
Feb 24 2010	Stipulation to dismiss the writ of certiorari pursuant to Rule 46 received.
Feb 24 2010	Petition Dismissed - Rule 46.

PETITION FOR WRIT OF CERTIORARI

Supreme Court, U.S.
FILED

09-38 JUL 7 - 2009

No OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

HEALTH CARE SERVICE CORPORATION,

Petitioner,

v.

JULI A. POLLITT and MICHAEL A. NASH,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-14, completely preempts -- and therefore makes removable to federal court -- a state court suit challenging enrollment and health benefits determinations that are subject to the exclusively federal remedial scheme established in FEHBA.

2. Whether the federal officer removal statute, 28 U.S.C. § 1442(a)(1), which authorizes federal removal jurisdiction over state court suits brought against persons "acting under" a federal officer when sued for actions "under color of [federal] . . . office," encompasses a suit against a government contractor administering a FEHBA plan, where the contractor is sued for actions taken pursuant to the government contract.

PARTIES TO THE PROCEEDING

All of the parties to the proceeding are identified in the case caption.

STATEMENT PURSUANT TO RULE 29.6

Health Care Service Corporation, an Illinois Mutual Legal Reserve Company, is not a publicly traded company, and no publicly held company owns ten percent or more of its stock. It has no parent corporation.

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Health Care Service Corporation ("HCSC"), an Illinois Mutual Legal Reserve Company, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (Petitioner's Appendix ("Pet. App.") 1a-4a) is reported at 558 F.3d 615. The order of the court of appeals denying HCSC's petition for rehearing and rehearing *en banc* is not reported. The opinion of the district court (Pet. App. 5a-8a) is not reported.

JURISDICTION

The judgment of the court of appeals was entered on March 10, 2009. HCSC timely filed a petition for rehearing and for rehearing *en banc*. The court of appeals denied the petition for rehearing and for rehearing *en banc* on April 8, 2009. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The text of statutes and regulations involved in the case is set out in the accompanying Appendix.

STATEMENT

A. Overview

This case lies at the intersection of three recent decisions of this Court: *Watson v. Philip Morris Cos.*, 551 U.S. 142 (2007), which examined when a private party may remove a state court case to federal court pursuant to the federal officer removal statute, 28 U.S.C.

§ 1442(a)(1); *Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677 (2006), which explored federal question jurisdiction in the context of health benefits plans governed by the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-14; and *Beneficial National Bank, N.A. v. Anderson*, 539 U.S. 1 (2003), which established the test for removal jurisdiction under the "complete preemption" doctrine.

Misinterpreting *Watson* and *Empire* and ignoring *Beneficial National Bank* entirely, the Seventh Circuit rejected complete preemption and severely limited application of the federal officer removal statute in a lawsuit involving enrollment and benefits with respect to the largest FEHBA plan, the Service Benefit Plan (or "the Plan"). Respondent Juli A. Pollitt, a federal employee enrolled in the Plan, commenced the lawsuit after the Department of Energy ("DOE") and Department of Labor ("DOL") mistakenly terminated the enrollment of her minor child in the Plan. In the original complaint, she sued to compel the enrollment of the minor in the Plan, as well as to challenge denials of benefits resulting from the termination of enrollment. Joining her in the lawsuit was the minor's father, Respondent Michael A. Nash, who is not a Plan enrollee. The DOE and DOL then fixed their error, resulting in the retroactive re-enrollment of the minor and reversal of the denials of benefits. Respondents nonetheless continued their lawsuit, seeking to collect millions of dollars in damages for alleged emotional distress caused by the enrollment termination.

All along, Respondents did not sue DOE, DOL, or any other government agency, notwithstanding that FEHBA and its regulations provide that the exclusive

remedy for enrollment or benefits grievances is an administrative appeal followed by a judicial review action *against the government in federal court.* Instead, they sued HCSC, the private party administering, pursuant to a government contract, the Plan in their state, and they did so in state court under state law. The district court saw through the ruse and, upon removal of the case, held that it had subject matter jurisdiction, dismissed the claims as preempted by FEHBA, and noted particularly that HCSC "was merely following the instructions of its principal, DOE." Pet. App. 8a. But the Seventh Circuit then vacated the district court's judgment, addressing just the district court's jurisdiction. Confusing complete preemption with occupation of the field preemption -- an obvious error in light of directions in *Beneficial National Bank* and *Empire* -- the Seventh Circuit rejected removal jurisdiction based on complete preemption. And contrary to *Watson*, it held that jurisdiction could be sustained under the federal officer removal statute, even in a government contractor situation, only if the government had specifically ordered each act about which Respondents complained.

The ultimate consequence of the Seventh Circuit's decision is to create Circuit splits on the availability of complete preemption generally, on the application of complete preemption in the FEHBA context specifically, and on the application of the federal officer removal statute to government contractors. The decision also has serious ramifications for the FEHBA program, a program that covers millions and costs billions: the court of appeals potentially has permitted an enrollee to evade -- in favor of a state court litigation alternative -- FEHBA's carefully calibrated federal

remedial scheme, simply by suing the wrong party. The Court should grant the petition for certiorari to correct a decision plainly at odds with this Court's precedents, to resolve the circuit conflicts, and to avoid litigation turmoil in a significant national federal program.

B. The Statutory, Regulatory, and Contractual Scheme

1. *The Service Benefit Plan*. *Empire* thoroughly summarized FEHBA's provisions and the workings of the Service Benefit Plan. With FEHBA, Congress "establishe[d] a comprehensive program of health insurance for federal employees." *Empire*, 547 U.S. at 682. The statute "authorizes the Office of Personnel Management (OPM) to contract with private carriers to offer federal employees an array of health-care plans." *Id.*; *see also* 5 U.S.C. § 8902(a). "Largest of the plans for which OPM has contracted, since 1960, is the Blue Cross Blue Shield Service Benefit Plan (Plan), administered by local Blue Cross Blue Shield companies." *Empire*, 547 U.S. at 682. Specifically, in recent years, the Blue Cross and Blue Shield Association ("BCBSA") -- the Plan's designated "carrier" -- has negotiated and signed the contract on behalf of local Blue Cross and Blue Shield companies, who then administer and underwrite the Plan in their respective localities. *See id.* at 683-84; *see also* Appellee's Separate Appendix in Ct. of Appeals ("C.A. App.") A88. HCSC is the local Blue Cross and Blue Shield company administering and underwriting the Plan in Illinois. The contract between OPM and BCBSA is known as "CS 1039." *See* C.A. App. A41.

2. *Enrollment*. Pursuant to OPM's regulations, federal employees enroll in the Plan through the particular federal agency for which they work. *See* 5 U.S.C. § 8905(a); 5 C.F.R. §§ 890.101(a), 890.102-.104, 890.301(d); *see generally* 5 C.F.R. Pt. 890, subpts. C, D, and K. CS 1039 emphasizes that the government, not the Blue Cross and Blue Shield companies, is responsible for enrollment. *See* C.A. App. A66 ("A person's eligibility for coverage, effective date of enrollment, the level of benefits (option), the effective date of termination or cancellation of a person's coverage, the date any extension of a person's coverage ceases, and any continuance . . . ceases, shall all be determined in accordance with regulations or directions of OPM given pursuant to [FEHBA].").

With respect to disputes about enrollment, OPM's regulations provide for administrative review within the pertinent employing federal agency. *See* 5 C.F.R. § 890.104. OPM's regulations also provide for judicial review thereafter, specifying that "[a] suit to compel enrollment . . . must be brought against the employing office that made the enrollment decision." *Id.* § 890.107(a).

Once enrolled in the Plan, enrollees are responsible for about 25% of the premium, with the government paying the remainder. 5 U.S.C. § 8906(b)(1), (b)(2), (f). The enrollees' and the government's contributions are placed in a fund in the U.S. Treasury, from which the Blue Cross and Blue Shield companies draw directly to pay benefits. *Id.* § 8909(a); *see also* 48 C.F.R. § 1632.170(b); *see generally Empire*, 547 U.S. at 684 (describing Plan's funding).

3. *Benefits Provisions*. OPM's "contracts with carriers, FEHBA instructs, 'shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as [OPM] considers necessary or desirable.'" *Empire*, 547 U.S. at 684 (quoting 5 U.S.C. § 8902(d)) (bracketed material added by Court); *see also* 5 U.S.C. § 8907(b). CS 1039, accordingly, instructs the carrier to provide benefits in accordance with an "appended brochure" -- or Statement of Benefits -- that outlines at length the panoply of medical costs the Plan will reimburse. *Empire*, 547 U.S. at 684; *see* C.A. App. A161-A287.

CS 1039 also outlines in detail the actions the Blue Cross and Blue Shield companies are required to take to recapture benefits erroneously paid. The contract provides: "If the Carrier or OPM determines that a Member's claim has been paid in error for any reason (except fraud and abuse), the Carrier shall make prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider." C.A. App. A68-A69. In so doing, "[t]he Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program," which may include providing notice to affected members or providers, offsetting future benefits payable to the member or to a provider, and bringing collection actions. *See id.*

4. *Benefits Disputes*. In addition to establishing administrative and judicial review procedures for grievances regarding enrollment, FEHBA and OPM's regulations likewise establish the remedy for benefits

disputes. Under FEHBA, each contract that OPM enters must require the carrier "to pay for or provide a health service or supply in an individual case" if OPM "finds that the employee . . . is entitled thereto under the terms of the contract." 5 U.S.C. § 8902(j). OPM has implemented this provision by establishing a mandatory administrative remedy at OPM for those who believe that the carrier has wrongfully denied benefits. *See* 5 C.F.R. § 890.105; *see also id.* § 890.107(d)(1).

OPM's regulations also provide that any court litigation over benefits may be brought only as an action *against OPM* for judicial review of its administrative decision. *See id.* § 890.107(c). The regulations expressly state that litigation "must be brought against OPM and not against the carrier or carrier's subcontractors." *Id.* In addition, no suit whatsoever shall be commenced "prior to exhaustion of the [OPM] administrative remed[y]." *Id.* § 890.107(d)(1). "[T]he recovery in such a suit shall be limited to a court order directing OPM to require the carrier to pay the amount of benefits in dispute." *Id.* § 890.107(c). Any lawsuit against OPM must be commenced in federal court, since FEHBA specifies that only the federal district courts and the Court of Federal Claims have jurisdiction over any FEHBA-related action against the United States. *See* 5 U.S.C. § 8912.

CS 1039 incorporates OPM's benefits-dispute regulations, repeating the regulatory provisions in section 2.8 of the contract. *See* C.A. App. A71-A73. The contract also emphasizes application of the OPM administrative remedy where a Blue Cross and Blue Shield company seeks to recapture benefits erroneously paid.

On this point, CS 1039 notes that "the Carrier shall . . . [s]uspend recovery efforts for a debt which is based upon a claim that has been appealed as a disputed claim under Section 2.8, until the appeal has been resolved." *Id.* at A69.

5. *OPM's Police Power*. Pursuant to authority delegated by Congress under 5 U.S.C. §§ 8913(a) and 8902(e), OPM is responsible for policing a carrier's provision of benefits and other activities under a FEHBA plan. OPM may penalize any carrier that fails to satisfy OPM's standards. For example, "[a] pattern of poor conduct or evidence of misconduct" -- such as "[u]sing fraudulent or unethical business or health care practices or otherwise displaying a lack of business integrity or honesty" -- "is cause for OPM to withdraw approval of the carrier" and to "effect corrective action." 48 C.F.R. § 1609.7001(c), (c)(2), (d).

6. *FEHBA's Preemption Provision*. FEHBA contains an express preemption provision, 5 U.S.C. § 8902(m)(1). As amended in 1998, the preemption provision states:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1). In enacting the current preemption language, which "broaden[ed]" an earlier version of the preemption clause (H.R. Rep. No. 105-374, at 9 (1997)), Congress sought "[t]o ensure uniform

coverage and benefits under plans OPM negotiates for federal employees." *Empire*, 547 U.S. at 686.

C. The Lawsuit

Respondent Juli A. Pollitt is an enrollee in the Service Benefit Plan. *See* C.A. App. A29, A313. Through her enrollment, HCSC also provides benefits to her minor son, as her dependent. *See id.* at A29-A30. In October 2003, Ms. Pollitt went on medical leave from her employer, the DOE, at which point her employer technically became the DOL. *Id.* at A312-A313. In June of 2007, the DOL instructed HCSC to change Ms. Pollitt's coverage from "Family" to "Self-Only," retroactive to October 19, 2003. *See id.* at A30. In light of the fact that HCSC had paid nearly four years of benefits on behalf of the minor despite (according to the DOL) his lack of coverage, and in accordance with its contractual duties, HCSC then requested that the providers who had rendered services to the minor after October 2003 refund any payments that HCSC had made on his claims. *See id.*

Ms. Pollitt, joined by the minor's father, Respondent Michael A. Nash, then commenced -- on September 10, 2007 -- this action in the Circuit Court for Lake County, Illinois. The original complaint sought reenrollment of the minor in the Plan, challenged the retroactive denial of benefits earlier paid on the minor's behalf, asserted that HCSC acted in bad faith in administering his coverage, and demanded more than $12 million in damages. *Id.* at A25-A26.

On October 3, 2007, HCSC received a copy of a letter from DOE to DOL indicating that the retroactive change the government earlier instructed had been a mistake and that the minor should be reinstated; two

days later, HCSC reinstated the minor. *Id.* at A30, A37. HCSC informed Ms. Pollitt that her son had been reinstated in the Plan and that it would rescind any refund requests concerning earlier benefits paid on her son's behalf. *See id.* at A289.

Based on the allegations in the original complaint, HCSC timely removed the case to the U.S. District Court for the Northern District of Illinois. Respondents proceeded *pro se* in the state court and subsequent federal proceedings.

D. Proceedings in the District Court

Once pending in federal court, HCSC moved to dismiss some of the claims in the original complaint as moot, because by then the minor had been re-enrolled and HCSC had reversed the retroactive denials of benefits. In addition, HCSC moved to dismiss all claims by both Respondents on the grounds that FEHBA preempted the claims and all claims of Mr. Nash for lack of standing (since he had no contractual relationship with HCSC).

The district court granted the motion to dismiss the original complaint, but also granted leave to amend the complaint, as Respondents sought an additional opportunity to draft a claim against HCSC that supposedly could survive FEHBA preemption. *See* Pet. App. 10a. In the amended complaint, and then a second amended complaint, which became the operative pleading, Respondents continued to challenge the alleged retroactive denial of benefits for their son. They alleged that HCSC had not rescinded earlier refund requests and requested an order from the District Court requiring HCSC to do so. *See* C.A. App. A306-A307, A309, A319-A320, A322. Respondents also

continued to raise a claim of bad faith under state law against HCSC. As with the bad faith claim in the original complaint, the bad faith claim in the second amended complaint contended, among other things, that HCSC breached a duty to protect Respondents' son from the federal government's purportedly wrongful enrollment determinations. *See id.* at A315-A316. In the second amended complaint, Respondents sought $1.8 million in compensatory and punitive damages. *See id.* at A322.

HCSC again moved for dismissal, and Respondents, in opposition, appeared to challenge, for the first time, the district court's jurisdiction. The district court then dismissed the second amended complaint, finding that "this case was properly removed from state court, that plaintiff Nash has no standing in this action, and that plaintiff Pollitt's claims are preempted and precluded by federal law." Pet. App. 8a.

In its dismissal order, the district court held that grievances concerning enrollment in and benefits under the Plan were subject exclusively to federal remedies, not state law. The district court noted that "Pollitt's remedy is governed by federal regulations that require[] suits to compel enrollment to be brought 'against the [federal agency] employing office that made the enrollment decisions.'" *Id.* at 7a (quoting 5 C.F.R. § 890.107(a)). The district court also emphasized that, on FEHBA benefits determinations, "Congress has delegated [OPM] . . . with the authority to procure and regulate the health benefits of federal employees, 5 U.S.C. § 8902(d), [and] OPM regulations expressly provide that all litigation involving benefits 'must be brought against OPM and not against the

carrier or carrier's subcontractors.'" Pet. App. 7a (quoting 5 C.F.R. § 890.107(d)(1)). The district court added that OPM has established "an administrative review mechanism to prosecute claims concerning FEHBA benefits and administration of FEHBA plans." *Id.* at 8a. Given these remedies, the district court ruled that "plaintiffs were required to prosecute their grievances through the administrative process." *Id.*

The district court then concluded by stating:

> The court shares plaintiffs' frustration about the course of conduct that led to their complaint, but notes that defendant was merely following the instructions of its principal, DOE. The temporary disenrollment of plaintiffs' son no doubt caused a great deal of anxiety and inconvenience to them. If they have a remedy . . . at all, however, it lies in the administrative process, not in this civil suit.

Id.

E. Proceedings in the Court of Appeals

On appeal, the Seventh Circuit, without oral argument, issued a published *per curiam* decision vacating the decision of the District Court and remanding for further proceedings. It reached only the question of the district court's jurisdiction.

The Seventh Circuit first rejected removal jurisdiction under "complete preemption," which the court described as a "misleadingly named doctrine that applies when federal law *has occupied a field*, leaving no room for any claim under state law." Pet. App. 2a-3a (emphasis added). The court then said: "But *Empire*

HealthChoice Assurance, Inc. v. McVeigh, 547 U.S. 677 (2006), holds that federal law does not completely occupy the field of health-insurance coverage for federal workers." Pet. App. 3a. Thus, according to the court, "*Empire HealthChoice* shows that the district court erred in allowing removal under [28 U.S.C.] § 1441 and dismissing the suit as completely preempted." Pet. App. 3a.

The Seventh Circuit next addressed jurisdiction under the federal officer removal statute, 28 U.S.C. § 1442(a)(1), "which says that 'any person acting under' a federal officer may remove a suit that depends on the defendant's following the directions issued by that federal officer." Pet. App. 3a. Rather than credit the district court's jurisdictional finding that HCSC "was merely following the instructions of its principal," *id.* at 8a -- a finding based on a sworn declaration, *see* C.A. App. A30 -- the Seventh Circuit emphasized allegations by Respondents that HCSC supposedly "drew an unwarranted inference [to terminate coverage] from the Department of Labor's failure to remit the self-and-family premium." Pet. App. 3a. The Seventh Circuit also cited Respondent's "contention" in the second amended complaint that "the Department did not direct HCSC to recoup four years' worth of benefits." *Id.* Because there was, in the Seventh Circuit's view, dispute over whether HCSC "did nothing but carry out the Department of Labor's instructions," the court ordered that "the district court must receive evidence, make appropriate findings, and then either retain or remand the case as the facts require." *Id.* at 3a, 4a.

The Seventh Circuit then gave instructions to the district court to guide the inquiry on remand. It said that,

"[t]o the extent HCSC was doing nothing but following the agency's orders, the case belongs in federal court." *Id.* at 4a. The court added that, in that instance, the case also "must be dismissed -- not because of 'complete preemption' but because suits related to a federal agency's health-benefit-coverage decisions must name the Office of Personnel Management or the employing agency rather than the insurance carrier. 5 U.S.C. § 8902(d); 5 C.F.R. §§ 890.104(a), 890.107(a), (c)." Pet. App. 4a. The Court also stated:

> But if the Department of Labor did not direct HCSC to change Pollitt's coverage, and just paid too little into the [Treasury] fund, then this case must be remanded to state court. There is no relevant federal 'directive,' just an agency's mistake to which the carrier overreacted. . . . Finally, if the Department directed HCSC to curtail future coverage, but did not direct it to recover past benefits from medical providers, then the claim for precipitate, mistaken recoupment should be remanded. 28 U.S.C. § 1367(c)(3).

Pet. App. 4a. While citing *Watson* once in its decision, the court in its guidance to the district court nowhere mentioned *Watson*'s teachings on removal by government contractors.[1]

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[1] Despite the remand of the case to the district court for further proceedings, there is no assurance that the removal jurisdiction issues can later be reviewed by this Court. In the event the district court remands the case to state court, the remand order is unappealable under 28 U.S.C. § 1447(c), even after completion of all state proceedings. Accordingly, this petition presents the

REASONS FOR GRANTING THE PETITION

The Seventh Circuit's decision in this case patently contradicts several of this Court's precedents, creates conflicts in the Circuits in already doctrinally complicated jurisdictional areas, and disrupts the administration of a significant national program. The Court should grant certiorari to resolve the Circuit conflicts and prevent the damage caused by the court of appeals' erroneous determination.

A. The Court of Appeals' Decision Contravenes This Court's Precedents

1. The Court of Appeals' Complete Preemption Holding Is Inconsistent with *Beneficial National Bank* and *Empire*

The centerpiece of the court of appeals' complete preemption ruling is that the doctrine supposedly turns on whether federal law "has occupied a field." Pet. App. 2a. Indeed, its decision in this case is just one in a long string of Seventh Circuit precedents finding that complete preemption depends on a federal statute occupying a particular field. *See, e.g., City of Joliet v. New West, L.P.*, 562 F.3d 830, 833 (7th Cir. 2009) ("The exception for 'complete preemption' . . . does not apply; no one argues that federal law occupies the fields of housing or municipal powers.") (internal citation omitted); *Rogers v. Tyson Foods, Inc.*, 308 F.3d 785, 787 (7th Cir. 2002) ("Complete, or field, preemption exists where Congress has so completely preempted a particular area that no room remains for

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Court with potentially its only opportunity to review the important jurisdictional questions presented.

any state regulation and the complaint would be necessarily federal in character.") (internal quotation marks omitted); *Lehmann v. Brown*, 230 F.3d 916, 919 (7th Cir. 2000) ("[T]he phrase 'complete preemption' has caused confusion -- evident in this case -- by implying that preemption sometimes permits removal. Unfortunately 'complete preemption' is a misnomer, having nothing to do with preemption and everything to do with federal occupation of a field."); *see also Covington v. Mitsubishi Motor Mfg. of Am., Inc.*, 51 Fed. Appx. 992, 994 (7th Cir. 2002) ("In matters related to removal under 28 U.S.C. § 1441, complete preemption means federal occupation of a field.").

The Seventh Circuit's repeated conflation of complete preemption and federal occupation of a field conflicts with this Court's leading precedent on complete preemption: *Beneficial National Bank v. Anderson*, 539 U.S. 1 (2003). There, the Court held that state law usury claims are completely preempted by the National Bank Act. In so holding, the Court stated that the test for complete preemption is whether federal law "provide[s] the *exclusive cause of action* for the claim asserted." *Id.* at 8 (emphasis added); *accord id.* at 9 ("[T]he dispositive question in this case [is]: Does the National Bank Act provide the exclusive cause of action for usury claims against national banks?"); *id.* at 9 n.5 ("the proper inquiry focuses on whether Congress intended the federal cause of action to be exclusive"); *id.* at 11 ("Because §§ 85 and 86 [of the National Bank Act] provide the exclusive cause of action for such claims, there is, in short, no such thing as a state-law claim of usury against a national bank.").

Beneficial National Bank made no mention at all of federal law occupying a field. Instead, the Court has used the phrase "occupation of the field" to describe a form of defensive, implied preemption existing where Congress pervasively regulates an area. *See Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992); *California v. ARC America Corp.*, 490 U.S. 93, 101 (1989). The Court has, for example, found occupation of the field preemption in the areas of transportation and sale of natural gas (*see Schneidewind v. ANR Pipeline Co.*, 485 U.S. 293, 310 (1988)), airline noise abatement and airport curfews (*see Burbank v. Lockheed Air Terminal, Inc.*, 411 U.S. 624, 633, 639 (1973)), and alien registration (*see Hines v. Davidowitz*, 312 U.S. 52, 73-74 (1941)). But then the Court in *Beneficial National Bank* said there were only "two categories of cases where this Court has found complete preemption -- certain causes of action under the LMRA [Labor Management Relations Act] and ERISA [Employee Retirement Income Security Act]." 539 U.S. at 8. Having not included the federal laws governing natural gas, airport noise and curfews, and aliens among completely preemptive statutes, the Court plainly has not equated complete preemption with occupation of the field.

Applying in this case, then, the correct test for complete preemption -- namely, whether FEHBA "provide[s] the exclusive cause of action for the claim asserted" (*Beneficial Nat'l Bank*, 539 U.S. at 8) -- Respondents' claims are completely preempted. The original complaint, which governs for removal purposes (*see Wis. Dep't of Corrections v. Schacht*, 524 U.S. 381, 390 (1998); *St. Paul Mercury Indem. Co. v. Red Cab Co.*, 303 U.S. 283, 291 (1938)), challenged a

termination of enrollment and related denials of benefits and alleged bad faith in connection with the enrollment termination and benefits denials. *See supra* p. 9. The court of appeals itself recognized that FEHBA provides the exclusive enforcement mechanism for enrollment and benefits disputes, *see* Pet. App. 4a (citing 5 C.F.R. §§ 890.104(a), 890.107(a), (c)), and other courts agree that FEHBA's remedies are exclusive.[2]

Nor can Respondents escape FEHBA's exclusively federal remedies, and thus complete preemption, by casting their allegations as a bad faith claim, as they did in part in the original complaint and then in the second amended complaint. In *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), the Court held that ERISA's remedy for denials of benefits completely preempted state tort claims that derived from the benefits denials. In language likewise apt in this case, the Court said: "[D]istinguishing between pre-empted and non-pre-empted claims based on the particular label affixed to them would 'elevate form over sub-

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[2] *See Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 398 (9th Cir. 2002) ("The federal remedies provided to aggrieved federal employees under the regulatory scheme are the only intended remedies under FEHBA; therefore, the federal remedies displace state remedies."); *Bryan v. OPM*, 165 F.3d 1315, 1318-19 (10th Cir. 1999) ("courts only have jurisdiction to review final actions, after exhaustion, and only one remedy is available": an administrative claim plus "judicial review" under "the Administrative Procedure Act"); *Bridges v. Blue Cross & Blue Shield Ass'n*, 935 F. Supp. 37, 41 (D.D.C. 1996) ("FEHBA sets forth an exclusive enforcement mechanism"); *see also Kight v. Kaiser Found. Health Plan of the Mid-Atlantic States, Inc.*, 34 F. Supp. 2d 334, 342 (E.D. Va. 1999) (same).

stance and allow parties to evade' the pre-emptive scope of [the federal statute] . . . simply 'by relabeling their contract claims as claims for tortious breach of contract.'" *Id.* at 214 (quoting *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 211 (1985)); *accord Burkey v. Gov't Employees Hosp. Ass'n*, 983 F.2d 656, 660 (5th Cir. 1993) (same, in FEHBA context).

Contrary to the court of appeals' conclusion, *Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677 (2006), supports -- not detracts -- from a finding of complete preemption over Respondents' claims. In *Empire*, the Court held that there was no federal jurisdiction over a FEHBA plan's reimbursement claim, which is a species of subrogation claim, against an enrollee. A central reason for the Court's holding was that FEHBA's exclusively federal remedies did not "extend" to "reimbursement claims between carriers and insured workers." 547 U.S. at 696.

However, the Court was careful to distinguish reimbursement actions from claims to which FEHBA's exclusive remedies *do* apply. With respect to benefits disputes, to which the FEHBA enforcement scheme indisputably does apply, the Court said that FEHBA's "prescriptions 'ensur[e] that suits brought by beneficiaries for denial of benefits *will land in federal court*.'" *Id.* (quoting *Empire HealthChoice Assurance, Inc. v. McVeigh*, 396 F.3d 136, 145 n.7 (2d Cir. 2005) (Sotomayor, J.)) (emphasis added). Thus, *Empire* compels, not undermines, a finding that FEHBA's exclusively federal remedies (again, the linchpin for complete preemption) completely preempt state law claims involving benefits disputes, making them "land" in federal court.

To be sure, the Court in *Empire* then considered an alternative argument for federal jurisdiction over subrogation claims: whether FEHBA's express preemption provision, 5 U.S.C. § 8902(m)(1), was itself "a jurisdiction-conferring provision." 547 U.S. at 697. The Court found the preemption provision "not sufficiently broad to confer federal jurisdiction," at least with respect to subrogation disputes. 547 U.S. at 698; *cf.* H.R. Rep. No. 105-374, at 16, 9 (1997) (Congress stating intent to "completely displace" state law in "FEHB program claims disputes"). It was upon this aspect of the Court's decision in *Empire* that the court of appeals seized in finding that "federal law does not completely occupy the field of health-insurance coverage for federal workers." Pet. App. 3a. But the court of appeals failed to recognize that *Empire* turned to the scope of the preemption provision only *after* rejecting the usual route to complete preemption -- the availability of an exclusively federal cause of action. In contrast, in this case, FEHBA's enforcement scheme *does* apply to Respondents' claims, meaning that there is no reason to look elsewhere (such as to the preemption provision) for federal jurisdiction.

In sum, *Beneficial National Bank* unequivocally holds that complete preemption hinges on the existence of an exclusively federal cause of action, and *Empire* explains that FEHBA's exclusive remedies for benefits grievances necessarily "channel[] disputes over coverage or benefits into federal court." *Empire*, 547 U.S. at 686-87. Having held that a FEHBA enrollment and benefits dispute covered by FEHBA's exclusive remedies nonetheless belongs in state court for lack of "occupation of a field," the court of appeals breached both precedents.

2. The Court of Appeals' Holding on the Federal Officer Removal Statute Is Contrary to *Watson*

The court of appeals' other jurisdictional holding concerns the federal officer removal statute, which provides that a state court action may be removed to federal court if commenced against "[t]he United States or any agency thereof or any officer (*or any person acting under that officer*) of the United States or of any agency thereof, sued in an official or individual capacity for any act under color of such office." 28 U.S.C. § 1442(a)(1) (emphasis added). The court of appeals ruled that that statute would provide a basis for federal jurisdiction over Respondents' claims, but only "[t]o the extent HCSC was doing nothing but following the [federal] agency's orders." Pet. App. 4a. The federal government has to have "direct[ed] HCSC to change Pollitt's coverage" and then also "direct[ed] it to recover past benefits from medical providers." *Id.*

The court of appeals' search for specific government directives is contrary to *Watson v. Philip Morris Cos.*, 551 U.S. 142 (2007) -- in particular, *Watson*'s teachings regarding removal by government contractors. In *Watson*, the Court discussed § 1442(a)(1)'s application to government contractors, though the case did not actually involve a government contractor. *Watson* concerned a cigarette manufacturer's efforts to invoke the federal officer removal statute when it was sued under state law for actions it took in conformance with federal regulations on cigarette testing. The Court held that "a highly regulated firm cannot find a statutory basis for removal in the fact of federal regulation alone." 551 U.S. at 153.

In rejecting application of the federal officer removal statute to companies that simply are *regulated* by the government, the Court contrasted such companies with government contractors. The Court noted that "lower courts have held that Government contractors fall within the terms of the federal officer removal statute, at least when the relationship between the contractor and the Government is an unusually close one involving detailed regulation, monitoring, or supervision." *Id.* But the Court said the "answer" to why government contractors should receive different treatment for purposes of § 1442(a)(1) than a merely regulated entity "lies in the fact that the private contractor in such cases is helping the Government to produce an item that it needs." *Id.* "The assistance that private contractors provide federal officers goes beyond simple compliance with the law and helps officers fulfill other basic governmental tasks." *Id.* The Court then gave the example (from a lower court case) of a defense contractor -- Dow Chemical Company -- who "fulfilled the terms of a contractual agreement by providing the Government with a product that it used to help conduct a war." *Id.* at 153-54 (citing *Winters v. Diamond Shamrock Chem. Co.*, 149 F.3d 387 (5th Cir. 1998)). "[A]t least arguably, Dow performed a job that, in the absence of a contract with a private firm, the Government itself would have had to perform." *Watson*, 551 U.S. at 154.

Watson, then, indicates that the relevant considerations for a government contractor to remove a case to federal court under § 1442(a)(1) include whether the relationship between the government and the contractor is a "close" one involving detailed oversight and whether the contractor is assisting the government in

responsibilities that otherwise would have been left to the government. The court of appeals paid no heed to these factors, instead focusing on the extent to which *specific* orders came from the government on both enrollment and benefits recoupment. Indeed, the Seventh Circuit found no special relevance at all in the fact that HCSC's conduct in the case stemmed from its obligations under a government contract. *See supra* p. 6.

Had the Seventh Circuit correctly applied *Watson*'s instructions concerning government contractors, it necessarily would have found jurisdiction under the federal officer removal statute. The relationship between FEHBA contractors and the government is an especially close one involving detailed supervision. At the time of FEHBA's inception, OPM's predecessor, the Civil Service Commission, described the "fundamental concepts underlying [FEHBA]" to include "mak[ing] the Commission responsible for the overall administration of the program while sharing day-to-day operating responsibilities with the employing agencies and the insurance carriers." H.R. Rep. No. 86-957, at 18 (1959) (statement of Civil Service Commission). Moreover, OPM has broad authority "for negotiating and regulating health benefits plans for federal employees" (*Empire*, 547 U.S. at 683), the FEHBA program is "comprehensive" (*id.* at 682), OPM sets the standards for carrier conduct (*see supra* p. 8), and contractors are bound to follow the federal employing agencies' directives on enrollment and OPM's determinations on disputed claims. *See supra* pp. 5, 7. Finally, absent FEHBA contracts, the government itself inevitably would be compelled to provide the health benefits administered and underwritten by FEHBA contractors,

in order to compete for talent with "[e]nlightened, progressive private enterprise [that] almost universally has been establishing and operating contributory health benefit programs for its employees." H.R. Rep. No. 86-957, at 2.

Given the close relationship between FEHBA contractors and the government on a matter critical to the government's day-to-day operations, it is enough to sustain jurisdiction under the federal officer removal statute that the claims arose in the context of HCSC "fulfill[ing] the terms of a contractual agreement." *Watson*, 551 U.S. at 153; *see also Maryland v. Soper*, 270 U.S. 9, 33 (1926) (the federal officer removal statute "does not require that the prosecution must be for the very acts which the officer admits to have been done by him under federal authority").

B. The Court of Appeals' Decision Creates Numerous Circuit Splits

The Court should grant certiorari in this case to resolve the several Circuit splits engendered by the Seventh Circuit's decision in this case -- on the complete preemption doctrine generally, on complete preemption in the FEHBA setting specifically, and on the availability of the federal officer removal statute to government contractors.

1. The Court of Appeals' Decision Conflicts with Other Circuits' Holdings on the Test for Complete Preemption

The Seventh Circuit is the only Circuit post-*Beneficial National Bank* to hold that complete preemption requires a finding that federal law occupies a field. At least six other Circuits have addressed com-

plete preemption after *Beneficial National Bank* and have concluded that the doctrine turns on the existence of an exclusively federal cause of action. *E.g.*, *Fayard v. Ne. Vehicle Servs., LLC*, 533 F.3d 42, 45 (1st Cir. 2008) ("Complete preemption is a short-hand for the doctrine that in certain matters Congress so strongly intended an exclusive federal cause of action that what a plaintiff calls a state law claim is to be recharacterized as a federal claim.") (emphasis removed); *Sullivan v. Am. Airlines, Inc.*, 424 F.3d 267, 275-76 (2d Cir. 2005) ("*Beneficial National Bank* explained that to determine whether a federal statute completely preempts a state-law claim within its ambit, we must ask whether the federal statute provides 'the exclusive cause of action' for the asserted state-law claim.") (quoting *Beneficial Nat'l Bank*, 539 U.S. at 9); *King v. Marriott Int'l Inc.*, 337 F.3d 421, 425 (4th Cir. 2003) ("[T]he touchstone of complete preemption is 'whether Congress intended the federal cause of action' to be 'the exclusive cause of action' for the type of claim brought by a plaintiff.") (quoting *Beneficial Nat'l Bank*, 539 U.S. at 18); *Mikulski v. Centerior Energy Corp.*, 501 F.3d 555, 564 (6th Cir. 2007), *cert. denied*, 128 S. Ct. 2426 (2008) ("Complete preemption requires a finding that 'the federal statutes at issue provided the exclusive cause of action for the claim asserted . . . .'") (quoting *Beneficial Nat'l Bank*, 539 U.S. at 7-8); *Moore-Thomas v. Alaska Airlines, Inc.*, 553 F.3d 1241, 1245 (9th Cir. 2009) ("[A] federal statute must provide the 'exclusive cause of action' for complete pre-emption to apply . . . .") (quoting *Beneficial Nat'l Bank*, 539 U.S. at 9); *Dunlap v. G&L Holding Group Inc.*, 381 F.3d 1285, 1291 n.9 (11th Cir. 2004) ("Jurisdiction based on complete preemption is . . . inapplicable here. . . .

[T]his federal banking regulation does not provide the exclusive cause of action for Dunlap's breach of contract claim . . . .").

The conflict between the Seventh Circuit's approach on complete preemption and the other Circuits' view is most starkly illustrated by the Second Circuit's *Sullivan* decision. There, the Second Circuit expressly rejected "equat[ing] the defense of field preemption, which defeats a plaintiff's state-law claim because federal law 'occupies the field' within which the state-law claim falls, with the doctrine of complete preemption, which creates federal subject-matter jurisdiction over preempted state-law claims." 424 F.3d at 273 n.7. The Second Circuit said: "[N]o Supreme Court case has ever held the two forms of preemption to be equivalent." *Id.* It cited with approval a scholar who has noted that "'another pathology attending field preemption lies in some courts' confusion of field preemption with complete preemption.'" *Id.* (quoting S. Candice Hoke, *Preemption Pathologies and Civic Republican Values*, 71 B.U. L. Rev. 687, 747 (1991)); *see also Fayard*, 533 F.3d at 45-46 (distinguishing complete preemption from situations where "Congress 'occupies the field'"; though "[e]xclusive federal regulation alone might preempt state claims, . . . it is the further presence of a counterpart federal cause of action that allows the state claim to be transformed into a federal one").

In light of the divergence in tests for complete preemption between the Seventh Circuit and the other Circuits, this case -- had it arisen elsewhere -- would have had a different result. In the First, Second, Fourth, Sixth, Ninth, and Eleventh Circuits, courts

would have found complete preemption, because they would have looked to the exclusivity of FEHBA's remedies, not to any federal occupation of the field.[3]

2. The Court of Appeals' Decision Conflicts with Other Circuits' Holdings on Complete Preemption in the FEHBA Setting

Not only is the Seventh Circuit's decision contrary to the other Circuits' decisions on the test for complete preemption, it creates a Circuit split on the more specific question of whether FEHBA completely preempts state law claims. Contrary to the Seventh Circuit's ruling, the Ninth Circuit has held that FEHBA *does* completely preempt state law causes of action. In *Botsford v. Blue Cross & Blue Shield of Montana, Inc.*, 314 F.3d 390 (9th Cir. 2002), the Ninth Circuit held that "FEHBA completely preempts" -- and therefore made removable to federal court -- a Service Benefit Plan enrollee's "state-law fraud claim," which sought increased benefits. *Id.* at 399, 392. Central to the Ninth Circuit's holding was that "Congress intended to limit suits over benefits under a FEHBA plan to only one defendant: the United States. The federal remedies provided to aggrieved federal employees under the regulatory scheme are the only intended remedies

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[3] HCSC should not be understood to assert that federal occupation of the field is lacking in this case. HCSC maintains that federal law does, in fact, occupy the field of FEHBA enrollment and benefits, notwithstanding that it may not occupy the field of subrogation (as noted in *Empire*). The point here, however, is that federal occupation of the particular field of regulation has no place in a complete preemption analysis and that the proper test for complete preemption -- the availability of an exclusively federal cause of action -- is satisfied in this case.

under FEHBA." *Id.* at 398. The Ninth Circuit added: "The existence of a detailed administrative enforcement scheme, coupled with Congress's decision to vest OPM with the power to enforce remedies, weigh on the side of finding that FEHBA remedies displace state-law remedies." *Id.* at 397. The Ninth Circuit also relied on the legislative history to the 1998 amendment to the FEHBA preemption provision, where Congress stated an intention that FEHBA "'*completely displace* State or local law relating to health insurance or plans.'" *Id.* at 399 (quoting H.R. Rep. No. 105-374, at 16 (1997)) (emphasis in original).

The Ninth Circuit has reaffirmed *Botsford*'s vitality after *Empire*. *See Cedars-Sinai Med. Ctr. v. Nat'l League of Postmasters*, 497 F.3d 972 (9th Cir. 2007). In that case, a medical provider had sued a FEHBA-plan administrator seeking payment for services provided to a FEHBA enrollee. In deciding the issue, the Ninth Circuit noted that *Botsford* sets forth (at least in its Circuit) the standards for complete preemption under FEHBA, *see id.* at 975, but the court emphasized that "*Botsford* involved claims brought by a plan enrollee for reimbursement related to the benefits that *he* received from a medical provider." *Id.* at 977 (emphasis in original). Ultimately, the Ninth Circuit distinguished *Botsford* and declined to extend complete preemption to claims by medical providers because -- unlike an enrollee -- "a third-party hospital could not be considered a 'covered individual' or other relevant party under FEHBA or its implementing regulations. Consequently, Cedars-Sinai does not have a remedy under the statute." *Id.* (quoting 5 C.F.R. § 890.105(a)(1)).

This case is like *Botsford*, not *Cedars-Sinai*. Respondents have remedies under FEHBA for their enrollment and benefits grievances. Accordingly, a court in the Ninth Circuit would have held that this case "arises under federal law, and [a] . . . district court had jurisdiction." *Botsford*, 314 F.3d at 399. The Seventh Circuit found oppositely because, focusing incorrectly on occupation of the field preemption, it deemed FEHBA incapable of complete preemption.[4]

3. The Court of Appeals' Decision Conflicts with the Second Circuit's Holding on Application of the Federal Officer Removal Statute to Government Contractors

A final conflict engendered by the Seventh Circuit's decision involves the application of the federal officer removal statute to government contractors. Two Circuits have considered § 1442(a)(1)'s application to government contractors in the wake of *Watson* -- the Seventh Circuit in this case and the Second Circuit in *Isaacson v. Dow Chem. Co.*, 517 F.3d 129 (2d Cir. 2008), *cert. denied*, 129 S. Ct. 1523 (2009). The Seventh Circuit's view that HCSC can establish federal

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[4] The Seventh Circuit's decision also conflicts with a series of unpublished decisions of Circuit and district courts holding -- after *Empire* -- that FEHBA completely preempts state law claims disputing benefits denials. *See Russell v. Gennari*, No. 1:07cv793, 2007 U.S. Dist. LEXIS 83771, at *15 (E.D. Va. Nov. 8, 2007), *aff'd*, No. 08-1046, 2008 U.S. App. LEXIS 15012 (4th Cir. July 15, 2008); *Center for Restorative Breast Surgery, LLC v. Blue Cross Blue Shield of La.*, No. 06-9985, 2007 U.S. Dist. LEXIS 34833, at *29 (E.D. La. May 10, 2007); *Ala. Dental Ass'n v. Blue Cross Blue Shield of La., Inc.*, No. 2:05-cv-1230-MEF (WO), 2007 U.S. Dist. LEXIS 685, at *20 (M.D. Ala. Jan. 3, 2007).

officer removal jurisdiction only if the government specifically directed the termination of Respondents' son's Plan enrollment and the subsequent retroactive denials of benefits cannot be squared with a far more expansive approach adopted in *Isaacson*.

In *Isaacson*, the Second Circuit upheld removal under § 1442(a)(1) by a federal contractor producing agent orange for the government, in a case in which the contractor was sued in tort associated with that production. The Second Circuit noted that "[t]he hurdle erected" for a contractor under § 1442(a)(1) -- at least those who "'assist[]'" and "'help[] carry out[] the duties or tasks of' officers" (517 F.3d at 137 (quoting *Watson*, 551 U.S. at 153)) -- is "quite low" (*id.*), and it set out the test as follows:

> [Private] entities must demonstrate that the acts for which they are being sued -- here, the production of dioxin in Agent Orange -- occurred *because of* what they are asked to do by the Government. . . . Defendants must only establish that the act that is the subject of Plaintiffs' attack (here, the production of the byproduct dioxin) occurred *while* Defendants were performing their official duties. . . . *And even if Plaintiffs were to prove that the dioxin contamination occurred because of an act not specifically contemplated by the government, it is enough that the contracts gave rise to the contamination. Indeed, whether the challenged act was outside the scope of Defendants' official duties, or whether it was specifically directed by the*

> *federal Government, is one for the federal -- not state -- courts to answer.*

517 F.3d at 137-38 (initial two emphases in original; last emphasis added; citations and internal quotation marks omitted).

Thus, under *Isaacson*, a government contractor need not show that the government "specifically directed" any of the activity at issue in a lawsuit; it is sufficient that the acts for which the contractor is sued occurred "while" the contractor was performing its government contracting obligations. Here, it is not disputable that the termination of enrollment and retroactive denials of benefits occurred while, and as a result of, HCSC's obligations to perform administrative functions under the government contract creating the Plan. That would have been sufficient under *Isaacson* to sustain jurisdiction under the federal officer removal statute. The Seventh Circuit, in conflict with *Isaacson*, required still more: a factual finding that the government *specifically directed* the termination of enrollment and recoupment of earlier-paid benefits.[5]

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[5] HCSC also should not be understood to assert that specific directions are lacking in this case. In any remand proceedings in the district court, HCSC will seek to show that it received specific instructions from the DOE and DOL and otherwise through CS 1039. But HCSC's point here is that it should not be required to make any such showing, because it is sued for actions in the course of performing its government contract.

C. The Court of Appeals' Decision Causes Confusion in Important Jurisdictional Areas and Seriously Undermines the FEHBA Program

Because the Seventh Circuit's decision disregards this Court's precedents and creates various Circuit splits, the Court should grant the petition. Furthermore, the serious consequences produced by the decision both for the jurisprudence of federal jurisdiction and for the FEHBA program buttress the case for granting the petition.

The Seventh Circuit's decision in this matter -- and, indeed, its long string of similar decisions -- equating complete preemption with occupation of the field preemption adds disorder to an already complex jurisdictional area. The complete preemption doctrine is a creature of case law, developed incrementally over more than forty years beginning with *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557 (1968). In the course of its evolution, the doctrine has been described as "confus[ing]" (*Lehmann v. Brown*, 230 F.3d 916, 919 (7th Cir. 2000)), "misleading" because of its name (*King v. Marriott Int'l, Inc.*, 337 F.3d 421, 425 (4th Cir. 2003)), and even "hopelessly muddled." Garrick B. Pursley, *Rationalizing Complete Preemption After Beneficial National Bank v. Anderson: a New Rule, a New Justification*, 54 Drake L. Rev. 371, 471 (Winter 2006); *see also id.* at 373 ("[P]erhaps no permutation of federal question removal has provoked more confusion among courts and commentators than the doctrine of complete preemption.").

Beneficial National Bank "adds clarity and predictability" to the area (Pursley, *supra*, at 439-40), establishing what even the dissenters in the case a-

greed was a "straightforward" standard that "a federal statute is completely preemptive when it 'provides the exclusive cause of action for the claim asserted.'" 539 U.S. at 16 (Scalia, J., dissenting) (quoting *Beneficial Nat'l Bank*, 539 U.S. at 8). That standard also has sound justification: "Where a state law claim is preempted by an exclusive federal cause of action, that state law claim may be removed to federal court because it is more efficient to allow removal than to require state-court adjudication of the preemption defense, dismissal of the state law claim, and the subsequent filing of a removable federal claim." Pursley, *supra*, at 440.

The Seventh Circuit, by looking to federal occupation of the field for complete preemption rather than the exclusivity of a federal cause of action, generates anew the confusion that *Beneficial National Bank* effectively alleviated. The Court should grant the petition in order the preserve the clarity it established in *Beneficial National Bank*.

In a similar vein, with respect to the federal officer removal statute, *Watson* was the Court's first foray in over 75 years into the topic of when a private person may remove a case under 28 U.S.C. § 1442(a)(1). *Cf. Maryland v. Soper*, 270 U.S. 9 (1926). *Watson* explained that entities simply regulated by federal law cannot remove under the federal officer removal statute, and it set general parameters for a government contractor's removal under the statute. The Seventh Circuit and the Second Circuit have now addressed § 1442(a)(1) in *Watson*'s wake, and they have taken opposite approaches, with the Seventh Circuit requiring *specific* government orders on each act involved in

the complaint, and the Second Circuit instead holding to a "low" threshold of proof "persons who, through contractual relationships with the Government, perform jobs that the Government otherwise would have performed." *Isaacson*, 517 F.3d at 137, 133. The Court should grant the petition to prevent another jurisdictional area from devolving into a muddled state. In fact, in *Watson* itself, the Court suggested that it might need to revisit the circumstances under which government contractors may remove under § 1442(a)(1); this case presents the Court with the opportunity. *See Watson*, 551 U.S. at 154.

Finally, the Court should grant the petition because the jurisdictional questions presented are critically important to the administration of the FEHBA program, a program that covers nearly 10 million individuals, costs billions annually, and each year involves hundreds of millions of claims for benefits. As part of the program, Congress insisted in FEHBA itself on a federal remedy for disputes over benefits and coverage. *See* 5 U.S.C. § 8902(j). In turn, OPM -- the agency responsible for overseeing FEHBA -- has stated expressly that fidelity to that federal remedy is paramount in order to sustain OPM's "central role" and to maintain "the principle of uniformity in the FEHB[A] Program." 60 Fed. Reg. 16037, 16037 (Mar. 29, 1995). The Seventh Circuit's decision sets up the troubling scenario that FEHBA enrollees will seek to bypass the relevant administrative remedy and federal judicial review and instead sue their plan administrator -- the wrong party -- in state court under state law; if they do choose to do so, they can avoid removal to federal court, absent specific directives from OPM (or an employing agency) to the FEHBA plan, directives that the

enrollees will have gone a long way to prevent by evading the federal administrative process in the first place.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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JULY 2009

APPENDIX

APPENDIX A

In the
United States Court of Appeals
For the Seventh Circuit

No. 08-3509

JULI A. POLLITT and MICHAEL A. NASH,
Plaintiffs-Appellants,

v.

HEALTH CARE SERVICE CORPORATION,
Defendant-Appellee.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 07 C 5961—**Robert W. Gettleman**, *Judge.*

SUBMITTED FEBRUARY 25, 2009—DECIDED MARCH 10, 2009

Before EASTERBROOK, *Chief Judge*, and ROVNER and EVANS, *Circuit Judges.*

PER CURIAM. Juli Pollitt, a federal employee, has health insurance as one of her job's fringe benefits. Health Care Service Corporation administers that coverage. In July 2007 HCSC stopped paying claims submitted on behalf of Pollitt's son Michael, and it also began trying to collect from health-care providers any payments made on Michael's behalf since 2003. According to HCSC, it did this because

the Department of Labor, which tells HCSC which federal employees have what coverage, instructed HCSC that Pollitt's coverage is for herself only, rather than for herself and her family. According to Pollitt's complaint in this suit, however, HCSC reached this conclusion on its own, because the Department of Labor had failed to pay the appropriate premium into a fund that covers the expense of the medical benefits. Instead of checking with the Department or with her, Pollitt's complaint alleges, HCSC abruptly stopped covering Michael's medical expenses and made demands for reimbursement that subjected her family to humiliation and expense until, just as abruptly, HCSC changed course in October 2007 and started paying the claims again—but even then, Pollitt asserts, HCSC did not inform medical providers, who continued trying to collect from Pollitt the back payments they thought HCSC was dunning them for.

The complaint, filed in state court, seeks to recover from HCSC under state-law theories of bad-faith conduct by insurers. HCSC removed the proceeding to federal district court, where it was dismissed as preempted by the Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901–14.

Preemption is a defense, and a federal defense does not allow removal. *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987); *Gully v. First National Bank*, 299 U.S. 109 (1936); *Bennett v. Southwest Airlines Co.*, 484 F.3d 907, rehearing denied, 493 F.3d 762 (7th Cir. 2007). Things are otherwise for "complete preemption," the misleadingly named doctrine that applies when federal law has occupied a field, leaving no room for any claim under state

law. See *Franchise Tax Board of California v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983). "Complete preemption" is not a defense; instead it represents a conclusion that all claims on the topic arise under federal law, so that 28 U.S.C. §1441 permits removal. But *Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677 (2006), holds that federal law does not completely occupy the field of health-insurance coverage for federal workers. *Empire HealthChoice* shows that the district court erred in allowing removal under §1441 and dismissing the suit as completely preempted.

The only possible source of authority to remove is 28 U.S.C. §1442(a)(1), which says that "any person acting under" a federal officer may remove a suit that depends on the defendant's following the directions issued by that federal officer. See *Watson v. Philip Morris Cos.*, 551 U.S. 142 (2007). HCSC insists that it did nothing but carry out the Department of Labor's instructions. Yet Pollitt maintains that HCSC acted unilaterally in concluding that her coverage was for self only rather than self and family—that HCSC drew an unwarranted inference from the Department of Labor's failure to remit the self and family premium. What is more, Pollitt contends, the Department did not direct HCSC to recoup four years' worth of benefits, the step that induced medical providers to demand that Pollitt reimburse them (and, she adds, to refuse to provide Michael with needed care unless she paid cash in advance for those services).

Because the parties are at odds about what (if any) directions the Department of Labor issued to HCSC, a district judge cannot accept HCSC's say-so and use

that as the basis of removal. Disputes about jurisdictional facts must be resolved after a hearing under Fed. R. Civ. P. 12(b)(1). The district court must receive evidence, make appropriate findings, and then either retain or remand the case as the facts require.

To the extent that HCSC was doing nothing but following the agency's orders, the case belongs in federal court and must be dismissed—not because of "complete preemption" but because suits related to a federal agency's health-benefits-coverage decisions must name as the defendant the Office of Personnel Management or the employing agency rather than the insurance carrier. 5 U.S.C. §8902(d); 5 C.F.R. §§ 890.104(a), 890.107(a), (c). See also *Boyle v. United Technologies Corp.*, 487 U.S. 500 (1988) (government contractor that strictly follows agency's directions is not liable under state law). But if the Department of Labor did not direct HCSC to change Pollitt's coverage, and just paid too little into the fund, then this case must be remanded to state court. There is no relevant federal "directive," just an agency's mistake to which the carrier overreacted. Whether 5 U.S.C. §8902(m)(1), which provides that the terms of a federal insurance contract supersede state law, affects the suit, would be a subject for the state court's consideration. Finally, if the Department directed HCSC to curtail future coverage, but did not direct it to recover past benefits from medical providers, then the claim for precipitate, mistaken recoupment should be remanded. 28 U.S.C. §1367(c)(3).

The judgment is vacated, and the case is remanded for further proceedings consistent with this order.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

JULI A. POLLITT and MICHAEL A. NASH,	)	
Plaintiffs,	)	No. 07 C 5961
v.	)	
	)	Judge Robert W. Gettleman
HEALTH CARE SERVICE CORPORATION.	)	
Defendant.	)	

ORDER

Plaintiffs Juli A. Pollitt ("Pollitt") and her former husband, Michael A. Nash ("Nash"), acting pro se, have sued defendant Health Care Service Corporation concerning the temporary removal of their son Michael Pollitt's enrollment and coverage in a service benefit plan (the "Plan") established pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901- 8914 ("FEHBA"). The Plan covered Pollitt and her son through her employment originally with the United States Department of Energy ("DOE") and later with the United States Department of Labor ("DOL"). Nash was not an enrollee in the Plan during any relevant period of time.

The dispute began in June 2007, when DOL instructed defendant, the administrator of the Plan

in Illinois, to change Pollitt's coverage from "family" to "self-only," retroactive to October 19, 2003. Following these instructions, defendant requested the providers who had rendered services to Michael Pollitt after October 2003 to refund any payments. Those providers then sought reimbursement from Pollitt and, as a result of the divorce decree between Pollitt and Nash, also apparently sought reimbursement from Nash because he was also financially responsible for his son's medical treatment.

In their original complaint filed in state court, plaintiffs sought reinstatement of Michael Pollitt to enrollment and reimbursement of any expenses or claims that they paid as a result of the change in Pollitt's coverage. Plaintiffs also alleged bad faith by defendant. The original complaint was filed October 22, 2007. Three weeks before that complaint was filed, on October 3, 2007, DOE instructed defendant to rescind its earlier instructions and reinstate Michael Pollitt to enrollment status. On or about October 5, 2007, defendant notified Pollitt that Michael had been reinstated in the Plan and rescinded any refund requests concerning earlier benefits paid for his treatment.

Defendant removed the action to this court from state court and filed a motion to dismiss based upon federal preemption. Plaintiffs were granted leave to filed an amended complaint based on state law claims alleging bad faith by defendant. Defendant has filed another motion to dismiss based on preemption, which the court grants.

First, Nash has no standing to sue defendant because he has had no contractual or other relationship with defendant. The fact that he might

be liable for his son's medical bills does not change this fact. Consequently, the complaint is dismissed as to Nash for lack of standing.

Next, Pollitt's remedy is governed by federal regulation that requires suits to compel enrollment to be brought "against the employing office that made the enrollment decisions." See 5 C.F.R. § 890.107(a). Because Congress has delegated the United States Office of Personnel Management ("OPM") with the authority to procure and regulate the health benefits of federal employees, 5 U.S.C. § 8902(d), OPM regulations expressly provide that all litigation involving benefits "must be brought against OPM and not against the carrier or carrier's subcontractors." 5 C.F.R. § 890.107(d)(1). Further, Congress has mandated that the terms of any health benefit contract established under FEHBA, "which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)" preempt state laws that "relate to health or insurance plans." 5 U.S.C. § 8902(m)(1). Following this directive, both the Plan contract and the OPM regulations establish a comprehensive administrative review procedure for resolving claims, like plaintiffs', regarding benefits and administration of FEHBA plans.

In light of this statutory and regulatory scheme, it is not surprising, as defendant points out, that the case law clearly holds that state law claims challenging the administration of a FEHBA-based Plan are preempted. See Zukor v. Inova Health Care Services, 200 U.S. Dist. LEXIS 21998 at *6-7 (E.D. Va. 2000); Botesford v. Blue Cross and Blue Shield of Montana, Inc., 314 F.3d 390, 393-97 (9th Cir. 2002).

Taken together, along with the contract and OPM regulations establishing an administrative review mechanism to prosecute claims concerning FEHBA benefits and administration of FEHBA plans, plaintiffs' were required to prosecute their grievances through the administrative process, but failed to do so. See Bridges v. Blue Cross and Blue Shield Association, 935 F. Supp. 37, 43 (D.D.C. 1996). To the extent that the complaint alleges breaches of fiduciary duties, defendant is correct that the courts have consistently held that FEHBA carriers owe no fiduciary duties to enrollees. See, Christensen v. Nat'l Savings and Trust Co., 683 F.2d 520, 522, 530-32 (D.C. Cir. 1982); Bridges, 935 F. Supp. at 44-45.

For the foregoing reasons, the court finds that this case was properly removed from state court, that plaintiff Nash has no standing in this action, and that plaintiff Pollitt's claims are preempted and precluded by federal law. The court shares plaintiffs' frustration about the course of conduct that led to their complaint, but notes that defendant was merely following the instructions of its principal, DOE. The temporary dis-enrollment of plaintiffs' son no doubt caused a great deal of anxiety and inconvenience to them. If they have a remedy it at all, however, it lies in the administrative process, not in this civil suit. Defendant's motion to dismiss is granted, and this matter is dismissed with prejudice.

ENTER: September 5, 2009
[sic: Entered September 5, 2008]

s/
Robert W. Gettleman
United States District Judge

APPENDIX C

United States Court of Appeals
For the Seventh Circuit
Chicago, Illinois 60604

April 8, 2009

Before

FRANK H. EASTERBROOK, *Chief Judge*
ILANA DIAMOND ROVNER, *Circuit Judge*
TERENCE T. EVANS, *Circuit Judge*

No. 08-3509	) Appeal from
	) the United States
JULI A. POLLITT and	) District Court for
MICHAEL A. NASH,	) the Northern
Plaintiffs-Appellants,	) District of Illinois,
	) Eastern Division
v.	)
	) No. 07 C 5961
HEALTH CARE SERVICE	) Robert W.
CORPORATION,	) Gettleman, *Judge.*
Defendant-Appellee.	)

Order

Defendant-appellee filed a petition for rehearing and rehearing en banc on March 24, 2009. No judge in regular active service has requested a vote on the petition for rehearing en banc, and all of the judges on the panel have voted to deny rehearing. The petition for rehearing is therefore DENIED.

APPENDIX D

UNITED STATES DISTRICT COURT, NORTHERN DISTRICT OF ILLINOIS

Name of Assigned Judge or Magistrate Judge	Robert W. Gettleman	Sitting Judge if Other than Assigned Judge	
CASE NUMBER	07 C 5961	DATE	11/15/2007
CASE TITLE	Juli Pollitt V Health Care Service Corp.		

DOCKET ENTRY TEXT:

Defendant Health Care Service's motion to dismiss is granted without prejudice. Plaintiff is given leave to file an amended complaint by 11/28/2007. Defendant's responsive pleading is due by 12/19/2007. Status hearing is set for 12/26/2007, at 9:15 a.m.

{Docketing to mail notice}

[Entered: 11/28/2007]

00:08

Courtroom Deputy	GDS

APPENDIX E

STATUTORY AND REGULATORY PROVISIONS

The Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901-8914, provides in pertinent part:

5 U.S.C. § 8902(a):

The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 or 8903a of this title, without regard to section 5 of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

5 U.S.C. § 8902(j):

Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title is entitled thereto under the terms of the contract.

5 U.S.C. § 8902(m)(1):

The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8903(1):

The Office of Personnel Management may contract for or approve the following health benefits plans:

(1) *Service Benefit Plan.* One Government-wide plan, which may be underwritten by participating affiliates licensed in any number of States, offering two levels of benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described by section 8904(1) of this title given to employees, annuitants, members of their families, former spouses, or persons having continued coverage under section 8905a of this title, or, under certain conditions, payment is made by a carrier to the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this tile.

5 U.S.C. § 8912:

The district courts of the United States have original jurisdiction, concurrent with the United States Court of Claims, of a civil action or claim against the United States founded on this chapter.

* * *

Other relevant statutory provisions include:

28 U.S.C. § 1331:

The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

28 U.S.C. § 1442(a)(1):

(a) A civil action or criminal prosecution commenced in a State court against any of the following may be removed by them to the district court of the United States for the district and division embracing the place wherein it is pending:

(1) The United States or any agency thereof or any officer (or any person acting under that officer) of the

United States or of any agency thereof, sued in an official or individual capacity for any act under color of such office or on account of any right, title or authority claimed under any Act of Congress for the apprehension or punishment of criminals or the collection of the revenue.

* * *

Relevant regulations include:

5 C.F.R. § 890.104:

(a) Who may file. Except as provided under § 890.1112, an individual may request an agency or retirement system to reconsider an initial decision of its employing office denying coverage or change of enrollment.

(b) Initial employing office decision. An employing office's decision is considered an initial decision as used in paragraph (a) of this section when rendered by the employing office in writing and stating the right to an independent level of review (reconsideration) by the agency or retirement system. However, an initial decision rendered at the highest level of review available within OPM is not subject to reconsideration.

(c) Reconsideration. (1) A request for reconsideration must be made in writing, must include the claimant's name, address, date of birth, Social Security number, name of carrier, reason(s) for the request, and, if applicable, retirement claim number.

(2) The reconsideration review must be an independent review designated at or above the level at which the initial decision was rendered.

(d) Time limit. A request for reconsideration of an initial decision must be filed within 30 calendar days from the date of the written decision stating the

right to a reconsideration. The time limit on filing may be extended when the individual shows that he or she was not notified of the time limit and was not otherwise aware of it, or that he or she was prevented by circumstances beyond his or her control from making the request within the time limit. An agency or retirement system decision in response to a request for reconsideration of an employing office's decision is a final decision as described in paragraph (e) of this section.

(c) Final decision. After reconsideration, the agency or retirement system must issue a final decision, which must be in writing and must fully set forth the findings and conclusions.

5 C.F.R. § 890.105:

(a) General. (1) Each health benefits carrier resolves claims filed under the plan. All health benefits claims must be submitted initially to the carrier of the covered individual's health benefits plan. If the carrier denies a claim (or a portion of a claim), the covered individual may ask the carrier to reconsider its denial. If the carrier affirms its denial or fails to respond as required by paragraph (c) of this section, the covered individual may ask OPM to review the claim. A covered individual must exhaust both the carrier and OPM review processes specified in this section before seeking judicial review of the denied claim.

(2) This section applies to covered individuals and to other individuals or entities who are acting on the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) Time limits for reconsidering a claim. (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the carrier in which to submit a written request for reconsideration to the carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the carrier's notice requesting additional information. The carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this section if the carrier fails to act within the time limit set forth in this paragraph (b)(2)(iii).

(3) The covered individual may write to OPM and request that OPM review the carrier's decision if the carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this section. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this section.

(4) The carrier may extend the time limit for a covered individual's submission of additional information to the carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) Information required to process requests for reconsideration. (1) The covered individual must put the request to the carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the carrier needs additional information from the covered individual to make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) Carrier determinations. The carrier must provide written notice to the covered individual of its determination. If the carrier affirms the initial denial, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the carrier's denial notice and include a copy of the denial notice as well as documents to support the covered individual's position.

(e) OPM review. (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the carrier's notice to the covered individual that the denial was affirmed;

(ii) If the carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this section, within 120 days after the date of the covered individual's timely request for reconsideration by the carrier; or

(iii) Within 120 days after the date the carrier requests additional information from the covered individual, or the date the covered individual is notified that the carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented

by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the carrier, OPM may:

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the carrier, the carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this section, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the carrier.

(5) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

5 C.F.R. § 890.107:

(a) A suit to compel enrollment under § 890.102 must be brought against the employing office that made the enrollment decision.

(b) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(c) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute *(5 U.S.C. chapter 89)*. A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the carrier or carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the carrier to pay the amount of benefits in dispute.

(d) An action under paragraph (c) of this section to recover on a claim for health benefits:

(1) May not be brought prior to exhaustion of the administrative remedies provided in § 890.105;

(2) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(3) Will be limited to the record that was before OPM when it rendered its decision affirming the carrier's denial of benefits.

OPPOSITION BRIEF

136 (2)

No. 09-38

Supreme Court, U.S.
FILED
AUG 7 - 2009
OFFICE OF THE CLERK

In The

Supreme Court of the United States

HEALTHCARE SERVICE CORPORATION,

Petitioner,

v.

JULI A. POLLITT and MICHAEL A. NASH,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

BRIEF IN OPPOSITION

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Pro Se Respondents

QUESTIONS PRESENTED

Respondents agree that question 2 of the Petition is at issue. Question 1, however, assumes facts that are still at issue themselves.

1. Whether Respondents' lawsuit is preempted under the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. § 8902(m)(1).

1a. Whether Respondents' lawsuit challenges any enrollment and or health benefit determination.

1b. Whether the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-14, establishes an exclusively federal remedial scheme for Respondents' complaints.

2. Whether Petitioner was a federal officer for purposes of the Federal Officer Removal Statute, 28 U.S.C. § 1442(a)(1), when it took the actions for which it was sued.

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I. STATEMENT OF THE CASE

A. Overview

This is a case where Petitioner, an entity operating on a fixed fee to administer a program of insurance, streamlined its operations to the point where Respondents suffered injury as a result. It failed to reconcile its coverage records on a regular basis and recklessly launched collection efforts without proper justification. These were not fiduciary duties but common law tort duties to persons to whom harm was foreseeable. The power to offset recoverable amounts against current payments to medical providers was an instrumentality with which any reasonable and prudent person would have behaved more carefully than Petitioner did here. Respondents' complaint is a tort action that does not attempt to enforce any contract.

The fact that Petitioner may have been fulfilling a contractual obligation to the federal government when it did those things is of no importance. As long as Petitioner was not a federal officer, as it clearly was not, its tort obligations to innocent parties had to come before the contract. The damages that Respondents seek will not be taken from any fund maintained on behalf of the people of the United States but from Petitioner's profits.

B. Fact At Issue

The question still at issue in this lawsuit is the degree of control, if any, exercised by the United

States Department of Labor (DOL) over Petitioner's actions. Petitioner alleges that it was only following orders. Respondents argue that the weight of evidence available so far, including a very ambiguous sworn declaration by an employee of Petitioner, points to there having been no such orders. Respondents have twice requested evidence of correspondence between Petitioner and other parties that might shed more light on the matter, but the requests, along with a motion for discovery to the District Court, have not yet been honored. The Seventh Circuit has ordered the District Court to hold an evidentiary hearing on the matter.

C. The Lawsuit

On July 31, 2007 Petitioner began withholding money otherwise due to ten medical providers for Respondents' son. Letters to the providers explained that Respondents' son had been uninsured since 2004 and payments made on his behalf would have to be recovered. The money at stake was over $30,000. Petitioner sent Respondent Juli Pollitt copies of the letters, a "New" benefits card backdated to 2004, and that was all. She received no other correspondence at that time from any party. She was not told that there had been a "benefits denial" or an "enrollment determination," and was given no explanation of how this happened or how to challenge it. Petitioner offered providers the opportunity to appeal this action but made no such offer to her.

On September 10, Respondents sued Petitioner in state court for bad faith and for estoppel, based on Respondents' reliance on payments made by Petitioner. They did not raise the question of whether the son had been properly enrolled or whether such payments were ever correct. The son was not a party to the suit. Respondents were not asserting his rights but their own. Respondent Michael A. Nash, who was not insured under this plan, joined in the suit because of his obligation, by court order, to pay half of his son's uninsured medical expenses.

The prayer for relief in this lawsuit demanded not only damages for Petitioner's bad faith but also reenrollment of Respondents' son. No special justification was given for this latter demand, other than the same tort and estoppel theories as the rest of the complaint. Respondents did not invoke any contract language to support it.

After Respondents sued, Petitioner, for the first time, sought an enrollment determination from DOL, the federal agency offering the plan. DOL informed Petitioner that the boy had been insured all along.

Petitioner reenrolled the boy on October 3, 2007 and informed Pollitt of this on October 5. They then moved the case to federal court, informed the Court that the matter was moot and motioned to have it dismissed. The Court dismissed Respondents' complaint without prejudice and offered them the opportunity to submit an amended one.

Respondents took time to verify that, as of late November 2007, their credit standing was still at risk. None of the providers that they contacted had been repaid or even informed that they were going to be repaid. The providers continued to hold Respondents accountable for that money. Respondents then filed a hastily written amended complaint, which they replaced five days later with a more carefully worded one. It focused entirely on the allegations of bad faith in the first complaint, and left out the claim of estoppel and the demand for reenrollment. Once again, the injuries alleged were entirely to Respondents and their son was not a party.

The Court held no evidentiary hearing on the subject of federal direction, which Respondents had questioned, both in their amended complaint and in a later motion, and ignored Respondents' motion for discovery on that issue. Ten months later, in September of 2008, after many docket events, few of them initiated by Respondents, the Court issued an order of dismissal. This order contained a statement that Respondents had filed their first complaint on October 22, 2007, and that this was after they had been notified of their son's reenrollment. In fact, Respondents had filed nearly a month before such notification. That one statement was the major reason for Respondents' appeal.

II. REASONS FOR DENYING THE WRIT

A. Respondents' Complaint Is Not Preempted Under The Federal Employees Health Benefits Act

1. FEHBA Preemption Is Limited

The FEHBA preemption provision 5 U.S.C. § 8902(m)(1), requires that "The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede any State or local law or any regulation issued there under which relate to health insurance or plans."

In *Empire Health Choice Assurance, Inc. v. McVeigh*, 547 U.S. 677 (2006), this Court noted that "Section 8902(m)(1)'s text does not purport to render inoperative any and all state laws that in some way bear on federal employee-benefit plans . . . and given that 8902(m)(1) declares no federal law preemptive, but instead, term of an OPM-BCBSA negotiated contract, a modest reading of the provision is in order." 547 U.S. at 689.

2. Respondents' Complaint Challenges No Coverage Determination

There is no coverage question at issue in Respondents' lawsuit. All parties now agree that Respondents' son was always insured during the four years in question.

Petitioner cites 5 C.F.R. § 890.107(a) to argue that the demand for re-enrollment in Respondents' original complaint meant that their suit should have been brought against "the employing office that made the enrollment decisions," which Petitioner's argued was DOL. However, DOL had made no such decision. Respondents sued the party that was taking money from their son's doctors, for which the doctors were dunning them, because of that party's own enrollment decision.

3. Respondents' Complaint Challenges No Benefits Determination

This case is not a dispute over benefits. It is not about those things to which one may be entitled under the terms of a contract of insurance. The amount of damages Respondents seek does not depend in any way on what benefits might be due or might have been due to them or their son.

In fact, the case has never involved a denial of benefits. Petitioner acknowledged this fact when it offered Respondents no opportunity to appeal such a denial. At no time during the dispute have Respondents ever asked for a benefits determination. They have never asked any party, any court of law or any other party, to read any contract of insurance for them and tell them what they or their son might be entitled to under its provisions. They have also never asked for anything that might be theirs or their son's by virtue of how an insurance plan is written. The

estoppel recovery that they sought relied on benefit determinations made long ago and would have been the same, had those determinations been correct or not.

4. Respondents' Complaint Does Not Concern Payments With Respect To Benefits

This is the area where this case most resembles *Empire* and where FEHBA preemption might apply. Both cases stemmed from carriers seeking reimbursement from third parties that might be seen as "payments with respect to benefits." The same argument to the contrary, however, suggested by this Court in *Empire* would apply here as well.

> . . . a claim for reimbursement ordinarily arises long after "coverage" and "benefits" questions have been resolved, and corresponding "payments with respect to benefits" have been made . . . 8902(m)(1)'s words may be read to refer to entitlement (or lack thereof) to Plan payment for certain healthcare services . . . and not to terms relating to the carrier's post payments right to reimbursement.

547 U.S. at 689.

In one respect, this case is even less of a federal matter than that one. In *Empire*, the subrogation recovery would have gone into a fund maintained on behalf of the federal government. In this case, Respondents' damages would come from Petitioner's profits and not from the fund.

The most important similarity with *Empire,* however, involved the final resolution of the matter. In that case this Court decided that even if preemption applied in reimbursement situations, it was "not sufficiently broad to confer federal jurisdiction," 547 U.S. at 689, and remanded the question of whether it applied to the state court. That is exactly what the 7th Circuit did here, "Whether 5 U.S.C. 8902(m)(1) . . . affects the suit, would be subject to the state court's consideration." *Pollitt v. Health Care Service Corporation*, 558 F.3d at 616 (7th Cir. 2009).

5. There Is No Circuit Split On Complete Preemption In The FEHBA Setting

The cases cited by Petitioner to support its view of FEHBA preemption usually have one thing in common. Someone received a benefits determination that he did not like and asked a court to read the contractual provision at issue and interpret it in a different way. Petitioner relies on one in particular to show a supposed circuit split, *Botsford v. Blue Cross Blue Shield of Montana*, 314 F.3d 390 (9th Cir. 2002). In that case, plaintiff wanted more reimbursement than the plan allowed for non-participating providers. Bruce Botsford was clearly asking the Court to give his insurance contract a different interpretation than the carrier had given it. Respondents are not doing that here.

Similar facts were present in other cases cited by Petitioner. In *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), where plaintiffs sought reimbursement for certain non-covered medical services, and in *Bridges v. Blue Cross and Blue Shield Association*, 935 F. Supp. 37 (D.D.C. 1996), where plaintiff wanted a smaller co-insurance charge than he had paid. Those cases are all entirely consistent with this one. The law is the same. The facts are different.

B. FEHBA Establishes No Exclusive Remedy For Respondents' Complaints

1. FEHBA Establishes No Exclusive Remedy For Respondent Juli Pollitt's Complaint

In *Beneficial National Bank v. Anderson*, 539 U.S. 1 (2003), this Court stated the test for complete preemption was "whether Congress intended the federal cause of action to be exclusive." 539 U.S. at 7. This Court stated that only three statutes met this test, The Labor Management Relations Act of 1947, The Employee Retirement Income Security Act of 1974 and the National Bank Act of 1863, 539 U.S. at 7. Nowhere did it mention anything about FEHBA, which had been modified into its present form five years earlier in 1998.

In *Sullivan v. American Airlines*, 424 F.3d 267 (2d Cir. 2005), the Court further clarified the holding in *Beneficial*. Preemption was never intended to deny plaintiffs a forum for their complaints, and it is

essential that a statute allow them a federal one if it is going to be considered completely preemptive. "When a state-law claim is removed to federal court, because a section of the LMRA, ERISA or the National Bank Act preempts it, the district court may then adjudicate the claim on the merits under the relevant preemptive statute." 424 F.3d at 276.

The authority of the federal courts in disputes between FEHBA Carriers and covered persons is limited to reviewing OPM determinations 5 C.F.R. § 890.105(a)(1), 5 C.F.R. § 890.107(a), (c), (d)(3). OPM's authority, in turn, is limited to reviewing benefits denials by carriers. 5 C.F.R. § 890.105(a)(1), (e)(1). OPM has no authority to deal with tort claims or questions of estoppel, and therefore those kinds of disputes could not have been heard originally in federal court. As the Court put it in *Sullivan*, "Because such disputes cannot be brought in federal court in the first instance, federal courts may not take jurisdiction over them simply to dismiss them." 424 F.3d at 276. FEHBA therefore offered no exclusive remedy for Respondents' complaints.

2. FEHBA provides No Remedy At All For Respondent Michael A. Nash's Complaint

Respondent Michael A. Nash is in many ways similar to the plaintiff in *Cedars-Sinai Med. Ctr. v. National League of Postmasters*, 497 F.3d 972 (9th Cir. 2007). His financial interest in this matter is the

same as those of his Co-Respondent. He is not acting on behalf of anyone other than himself. However, because he is not a plan "covered individual" 5 C.F.R. § 890.101(a), he has no access to the FEHBA enforcement mechanism, 5 C.F.R. § 890.105(a)(1), (b)(1). Even if it is found that FEHBA somehow provides a remedy to his Co-Respondent it would still provide none to him and FEHBA preemption would not apply to him.

3. There Is No Circuit Split On The Test For Complete Preemption

The standard for complete preemption applied by the Seventh Circuit in this matter is the same as was applied in *Beneficial* and in all of the six circuits cited by Petitioner. Whether it is called "exclusive remedy" or "completely occupy," neither was met in this matter. None of the six cases actually found complete preemption. *Sullivan* was a perfect example. It denied removal in a case involving the Railway Labor Act, stating that no form of preemption, complete or any other, was appropriate in that matter. FEHBA does not offer an exclusive remedy for Respondent Juli A. Pollitt's complaint and none at all for Respondent Michael A. Nash. This case would have been decided the same way in any one of the circuits.

C. Petitioner Was Not A Federal Officer For Purposes Of Removal Jurisdiction

1. This Case Is Not Inconsistent With *Watson v. Phillip Morris Cos.*

The Federal Officer Removal Statute, 28 U.S.C. § 1442(a)(1) specifies that actions are removable if they are against "any officer (or any person acting under that officer) . . . sued . . . for any act under color of such office."

In *Watson v. Phillip Morris Cos.*, 551 U.S. 142 (2007), this Court discussed how one becomes such an officer. This Court said that a private firm's activities do not necessarily fall under this statue even if they are "highly supervised and monitored." 551 U.S. at 147. It defined "acting under" to include "helping the Government produce an item that it needs . . . performing a job that in the absence of a contract with a private firm, the government would have had to perform." 551 U.S. at 148.

Such "acting under" was found in *Isaacson v. Dow Chem. Co.*, 517 F.3d 129, 136 (2d Cir. 2008). The contractor's production of "Agent Orange" to win a war was considered a necessary government function.

Although it is a case dealing with immunity and not removal, Respondents are persuaded by the reasoning in *Houston Community Hospital v. Blue Cross Blue Shield of Texas*, 481 F.3d 265 (5th Cir. 2007). The Court cautioned that "Not every activity in which government might decide to engage is a function of government in private hands," 481 F.3d at

272, and that FEHBA Carriers (are) not exercising any governmental function because "it is not apparent that [the carriers] themselves perform any function that OPM is itself charged with performing." 481 F.3d at 270. Petitioner had no "official" duties and did nothing in any "official" capacity.

2. There Is No Circuit Split On Application Of The Federal Officer Removal Statute To Government Contractors

The standard the Seventh Circuit applied for who was a federal officer was consistent with *Watson, Isaacson* and *Houston*. The holding in *Isaacson* differs from this case for the same reason that it does from that in *Houston*. It applies the same law to a very different set of facts, one in which a necessary government function was being performed.

D. The Court Of Appeals Decision In No Way Undermines The FEHBA Program

1. Respondents' Complaint Does Not Undermine The Uniformity Of FEHBA Benefits

In *Blue Cross Blue Shield of Illinois v. Cruz*, 495 F.3d 510 (7th Cir. 2006), the Court examined the public policy issues Congress considered when it created preemption. It "wanted federal employees to have the same benefits under their health plan no matter what state they were in." 495 F.3d at 513. It

stated that the fact that one insured might receive more money from a provider because of a tort claim in addition to his benefit claim did not make the benefits any less uniform. "The benefits are uniform, though the net financial position of an insured who has a potential tort claim is not." 495 F.3d at 513.

The fact that some other state might have different rules on either bad faith or estoppel did not make benefits provided under this plan any less uniform. Nor is a state court determination on these subjects a benefits determination just because it might improve the financial position of a beneficiary.

2. Congress Never Intended To Eliminate Estoppel Or Bad Faith Claims

Respondents were never entirely certain exactly what happened here or that their son's disenrollment might not have been somehow justified under the terms of the plan. Estoppel is the obvious remedy in this kind of situation. It avoids all such questions. If Congress had intended to deny it to people in Respondents' position, and require them to confront that uncertainty, it would have said so when it established FEHBA preemption. The same can be said of Respondents' claim of bad faith. If Congress had intended to allow FEHBA carriers to conduct their business entirely without regard for those who might be injured by that conduct, it would have said that as well.

III. CONCLUSION

Petitioner should be denied a writ of certiorari.

Respectfully submitted,

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REPLY BRIEF

137 (3)

Supreme Court, U.S.
FILED
AUG 18 2009
OFFICE OF THE CLERK

No. 09-38

IN THE
Supreme Court of the United States

HEALTH CARE SERVICE CORPORATION,

Petitioner,

v.

JULI A. POLLITT and MICHAEL A. NASH,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

PETITIONER'S REPLY BRIEF

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Health Care Service Corporation ("HCSC"), an Illinois Mutual Legal Reserve Company, respectfully files this reply in support of its petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit in this case.

ARGUMENT

A. The Seventh Circuit's Complete Preemption Holding Warrants This Court's Review

In its petition, HCSC showed that the Seventh Circuit's complete preemption ruling, which conflated complete preemption with the defensive preemption concept of federal occupation of a field, contravened this Court's prior decisions in *Beneficial National Bank, N.A. v. Anderson*, 539 U.S. 1 (2003), and *Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677 (2006). It also created Circuit splits on the test for complete preemption generally, as well as on application of complete preemption in suits against plans governed by the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-14.

In response, Respondents do not defend the Seventh Circuit's notion that occupation of the field is the test for complete preemption; instead, they recognize that, in *Beneficial National Bank*, "this Court stated the test for complete preemption was 'whether Congress intended the federal cause of action to be exclusive.'" Resp. Br. at 9 (quoting *Beneficial Nat'l Bank*, 539 U.S. at 7). But Respondents then seek to avoid the problems the Seventh Circuit's ruling creates by asserting that, under the proper test for complete preemption, there still would be no federal jurisdiction in this case. The centerpiece of their presentation is that suppos-

edly none of their grievances are subject to FEHBA's exclusively federal remedies. On this score, Respondents widely miss the mark.

Respondents first contend that the case has never concerned their son's *enrollment* in the Service Benefit Plan ("the Plan"), which is the FEHBA plan at issue. *See* Resp. Br. at 6. With the case purportedly not involving an enrollment question, Respondents argue that their suit can steer clear of FEHBA's exclusive remedy for enrollment disputes. *See* 5 C.F.R. §§ 890.104, 890.107(a); Pet. at 5, 18. Yet, Respondents' original complaint in the case (the one that led to removal to federal court) quite plainly asked a court to do the following: "Enter judgment for Plaintiffs and against Defendant, directing Defendant to provide medical insurance coverage for Plaintiffs' minor child . . . from July 31, 2007 until such time as either he reaches 21 years of age or Plaintiff Juli A. Pollitt chooses to remove him from her policy." C.A. App. A25; *accord id.* at A23 ("On July 30, 2007 Defendant informed Plaintiffs for the first time that there *was no medical coverage* for their minor child") (emphasis added). And Respondents' current statement that their case involves no enrollment questions is at odds with both the district court's and the court of appeals' findings that the dispute centers on the "temporary dis-enrollment of plaintiffs' son." Pet. App. 8a (district court's decision); *see also id.* at 4a (court of appeals holding that, if jurisdiction could be sustained under the federal officer removal statute, the case must be dismissed, in part, because of FEHBA's remedy for enrollment disputes).

Next, Respondents maintain that their case can escape complete preemption because purportedly it likewise does not fit FEHBA's exclusive remedy for challenging benefits denials. *See* 5 U.S.C. § 8902(j); 5 C.F.R. §§ 890.105, 890.107(c). Again, their pleadings show otherwise. Emphasizing that their grievance concerns an alleged denial of benefits (resulting from a mistake about enrollment), Respondents' original complaint asked a court to "[e]nter judgment for Plaintiffs and against Defendant, directing Defendant to honor all medical insurance claims for their minor child . . . for the period of time from June 16, 1993 to July 30, 2007." C.A. App. A25. The second amended complaint (*i.e.*, the currently operative pleading) also alleges that, during the period relevant to the case, "Defendant, upon discovering the [enrollment] discrepancy in question, opted to *retroactively deny coverage* for [Respondents' son]," and the second amended complaint requests a court order directing HCSC to halt any efforts to recollect earlier paid, but now denied, benefits. *Id.* at A318, A322 (emphasis added). Additionally, contrary to Respondents' view that their case "is not a dispute over benefits" (Resp. Br. at 6), both the district court and the court of appeals found the dispute covered by FEHBA's denial-of-benefits remedy. *See* Pet. App. 4a (court of appeals noting applicability of 5 C.F.R. § 890.107(c)); *id.* at 7a (district court noting that "both the Plan contract and the OPM regulations establish a comprehensive administrative review procedure for resolving claims, *like plaintiffs'*, regarding benefits and administration of FEHBA plans") (emphasis added).

Just because the benefits denials were retroactive does not mean they fall outside of FEHBA's exclusive

remedial scheme for benefits disputes. FEHBA directs the U.S. Office of Personnel Management ("OPM") to adjudicate administratively any "individual case" where a carrier does not "pay for or provide a health service or supply" based on the "the terms of the contract." 5 U.S.C. § 8902(j). Here, after initially paying claims, HCSC determined it should not pay those claims because the federal employing agencies had indicated that Respondents' son was not enrolled, and the FEHBA contract mandates payment only to enrolled persons. *See* C.A. App. A67-A68. With payment now having been denied by HCSC based on its view of its contractual obligations, nothing prevented an administrative claim to challenge the benefits denial.[1]

Moreover, Respondents cannot avoid FEHBA's benefits remedy by couching their claims in terms of bad faith or estoppel. *See* Resp. Br. at 10. As explained in the petition, this Court in ERISA and other settings

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[1] An administrative claim could have been filed by Respondent Juli A. Pollitt as the enrolling federal employee. *See* 5 C.F.R. § 890.105(a)(2). Respondent Michael A. Nash is not enrolled in the Plan, but could have filed an administrative claim on his son's behalf, with appropriate documentation. *See id.* HCSC agrees with Respondents that Nash has no standing in his own right to pursue the OPM remedy. *See* Resp. Br. at 10-11. Indeed, the district court held that, because he had no contractual relationship with HCSC, he lacked Article III standing for the lawsuit. *See* Pet. App. 6a-7a. Nonetheless, though complete preemption for Nash's claims might become more complicated due to his lack of standing (but we do not concede complete preemption is inapplicable to him), Pollitt plainly was a Plan enrollee who could invoke FEHBA's remedies, thereby making her allegations completely preempted. The federal courts have removal jurisdiction so long as any one claim in a complaint is removable. *See* 28 U.S.C. §§ 1367, 1441(c).

and lower courts in the FEHBA context have rejected litigants' efforts to invoke tort theories of recovery in order to evade applicable denial-of-benefits remedies. *See* Pet. at 18-19 (citing *Aetna Health Inc. v. Davila*, 542 U.S. 200, 214 (2004); *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 211 (1985); *Burkey v. Gov't Employees Hosp. Ass'n*, 983 F.2d 656, 660 (5th Cir. 1993)); *see also Hayes v. Prudential Ins. Co. of Am.*, 819 F.2d 921, 926 (9th Cir. 1987) (in FEHBA case, holding that "[t]ort claims arising out of the manner in which a benefit claim is handled are not separable from the terms of the contract"). In fact, in *Botsford v. Blue Cross & Blue Shield of Montana, Inc.*, 314 F.3d 390 (9th Cir. 2002), which is the principal decision here creating the Circuit split and which Respondents seek to distinguish as involving (supposedly unlike their claims) a "benefits determination" (Resp. Br. at 8), the FEHBA enrollee styled his claim as one for "state-law fraud." *Botsford*, 314 F.3d at 392. The Ninth Circuit still found complete preemption because a "dispute over benefits -- precisely the kind of dispute that FEHBA preempts -- underlies Botsford's claim." *Id.* at 395.

Nor can Respondents avoid FEHBA's benefits remedy by analogizing their state law claims to the "reimbursement" matters at issue in *Empire*. Reimbursement as addressed in *Empire* is a form of subrogation; it occurs where "a Plan beneficiary, injured in an accident, whose medical bills have been paid by the Plan administrator, recovers damages (unaided by the carrier-administrator) in a state-court tort action against a third party alleged to have caused the accident," and the Plan, as a result of the duplicative payments, seeks to recapture the earlier-paid

benefits. *Empire*, 547 U.S. at 682. In that instance, the Court said that a carrier's claim for reimbursement against an enrollee "plausibl[y]" -- though not necessarily -- might not involve a benefits issue because "a claim for reimbursement ordinarily arises long after 'coverage' and 'benefits' questions have been resolved." *Id.* at 697 (quoting 5 U.S.C. § 8902(m)(1)).

In contrast, Respondents' lawsuit contests HCSC's re-examination of the *initial* right to benefits (as a result of a federal employing agency's retroactive termination of the minor's enrollment). To use *Empire*'s terms, Respondents' claims "relat[e] to the *beneficiary's* entitlement (or lack thereof) to Plan payment for certain health-care services he . . . has received" and not to a carrier's "post payments right" to subrogation. 547 U.S. at 697 (emphasis in original). As a matter involving how "'coverage' and 'benefits' questions" were "resolved," Respondents -- as *Empire* directs -- should have pursued an administrative appeal at OPM, and FEHBA and OPM's regulations thereafter would "channel[] [any] disputes over coverage or benefits into federal court." *Id.* at 686-87; *see also id.* at 696 ("OPM's regulation, 5 C.F.R. § 890.107(c) (2005), instructs enrollees who seek to challenge benefits denials to proceed in court against OPM," and such a case will "land in federal court") (internal quotation marks omitted).

In sum, Respondents raise state law claims that are subject to FEHBA's exclusively federal remedies for enrollment and benefits disputes. The Seventh Circuit's holding that the claims nonetheless are not completely preempted -- because of the Seventh Circuit's erroneous focus on "occupation of the field" (*see*

Pet. App. 2a-3a) rather than the availability of an exclusively federal remedy -- is contrary to *Beneficial National Bank* and *Empire*. And by rejecting complete preemption in a FEHBA case arising from a benefits dispute, the Seventh Circuit has created a Circuit split with the Ninth Circuit's *Botsford* decision, as well as acted in conflict with numerous Circuit decisions utilizing the availability of an exclusively federal remedy as the touchstone for complete preemption. *See* Pet. at 24-27.

B. The Seventh Circuit's Holding on the Federal Officer Removal Statute Warrants This Court's Review

In its petition, HCSC also showed that the Seventh Circuit's holding on the federal officer removal statute, 28 U.S.C. § 1442(a)(1), is inconsistent with *Watson v. Philip Morris Cos.*, 551 U.S. 142 (2007). The Seventh Circuit's § 1442(a)(1) ruling also creates a Circuit split with *Isaacson v. Dow Chemical Co.*, 517 F.3d 129 (2d Cir. 2008), *cert. denied*, 129 S. Ct. 1523 (2009). In particular, with respect to the Circuit split, the Seventh Circuit's insistence that HCSC can invoke § 1442(a)(1) only "[t]o the extent . . . HCSC was doing nothing but following the [relevant] agency's orders" (Pet. App. 4a) conflicts with the Second Circuit's view that a government contractor may remove a case whenever the private conduct at issue "occurred *while* Defendants were performing their official duties" and irrespective of "whether the challenged act . . . was specifically directed by the federal Government." *Isaacson*, 517 F.3d at 137, 138 (emphasis in original).

Respondents do not focus on the distinction between private contractors who receive specific government

direction and those simply fulfilling what they believe to be their contractual obligations. Instead, they assert that the federal officer removal statute can *never* apply to a FEHBA contractor because supposedly providing insurance -- even if done by the government itself -- is not a "governmental function." Resp. Br. at 13. In that sense, Respondents' argument is at odds even with the Seventh Circuit's decision, since the court of appeals at least would find § 1442(a)(1) applicable if HCSC, in exercising its FEHBA functions, acted pursuant to express directions from a federal agency. Ultimately, Respondents' effort altogether to exclude FEHBA cases from the federal officer removal statute's scope injects an entirely new concept into § 1442(a)(1) jurisprudence -- namely, whether some of the government's operations deserve protection under § 1442(a)(1) but others do not. Pressing for the adoption of a novel legal standard is more suited for merits briefing than an opposition to certiorari, with the defense in the latter typically being that the approach *actually* adopted by the court of appeals is correct or at a minimum is consistent with the other Circuits' viewpoints.

In any event, Respondents' assertion that FEHBA contractors, for purposes of § 1442(a)(1), perform "no 'official' duties" is unsustainable. Resp. Br. at 13. The contention derives from an official immunity decision -- *Houston Community Hospitals v. Blue Cross & Blue Shield of Texas, Inc.*, 481 F.3d 265 (5th Cir. 2007) -- not a removal case. This Court has held, and even the court in *Houston Community Hospitals* recognized, that "the test for removal" under § 1442(a)(1) is "broader . . . than the test for official immunity." *Willingham v. Morgan*, 395 U.S. 402, 405 (1969); *accord*

Houston Cmty. Hosps., 481 F.3d at 273. Further, if providing insurance could not constitute "a necessary government function" (Resp. Br. at 13), then whole swaths of the federal government's endeavors do not involve official acts, including providing insurance to the elderly under Medicare, providing (with the states) insurance to the indigent through Medicaid, and providing insurance to flood victims under the National Flood Insurance Program. *Cf. Pani v. Empire Blue Cross Blue Shield*, 152 F.3d 67, 72-74 (2d Cir. 1998) (holding that Medicare carrier enjoys official immunity); *Midland Psychiatric Assocs., Inc. v. United States*, 145 F.3d 1000, 1003-05 (8th Cir. 1998) (same); *Russell v. Gennari*, No. 1:07cv793, 2007 U.S. Dist. LEXIS 83771, at *17 (E.D. Va. Nov. 8, 2007), *aff'd*, 284 Fed. Appx. 98 (4th Cir. 2008) (holding that FEHBA carrier enjoys official immunity).

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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AUGUST 2009

JOINT APPENDIX

Supreme Court U.S.
DEC 11 2009
OFFICE OF THE CLERK

(4)

No. 09-38

IN THE

Supreme Court of the United States

HEALTH CARE SERVICE CORPORATION,

Petitioner,

v.

JULI A. POLLITT and MICHAEL A. NASH,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

JOINT APPENDIX

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PETITION FOR WRIT OF CERTIORARI FILED JULY 7, 2009
CERTIORARI GRANTED OCTOBER 13, 2009

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U.S. District Court
Northern District of Illinois (Chicago)
Relevant Docket Entries for *Pollitt v. Health Care Service Corp.*, No. 1:07-cv-05961

Date Filed	No.	Docket Text
10/22/2007	1	NOTICE of Removal from Circuit Court of Lake County, case number (07L709) filed by Health Care Service Corporation (Exhibits) (mb) (Entered: 10/23/2007)
10/22/2007	2	CIVIL Cover Sheet (mb) (Entered: 10/23/2007)
10/26/2007	6	MOTION by Defendant Health Care Service Corporation to dismiss (Witt, Helen) (Entered: 10/26/2007)
10/26/2007	7	MEMORANDUM by Health Care Service Corporation in support of motion to dismiss 6 (Witt, Helen) (Entered: 10/26/2007)
11/05/2007	9	PRO SE Appearance by Plaintiff Juli A. Pollitt (mb) (Entered: 11/07/2007)
11/05/2007	10	PRO SE Appearance by Plaintiff Michael A. Nash (mb) (Entered: 11/07/2007)

Date Filed	No.	Docket Text
11/15/2007	11	MINUTE entry before Judge Robert W. Gettleman: Defendant Health Care Service's motion to dismiss is granted without prejudice. Plaintiff is given leave to file an amended complaint by 11/28/2007. Defendant's responsive pleading is due by 12/19/2007. Status hearing is set for 12/26/2007, at 9:15 a.m. Mailed notice (lcw) (Entered: 11/28/2007)
11/28/2007	12	AMENDED Complaint by Plaintiffs Juli A. Pollitt and Michael A. Nash against Defendant Health Care Service Corporation. (ar) (Entered: 11/29/2007)
12/03/2007	13	MOTION by Plaintiffs for leave to amend their complaint. (ar) (Entered: 12/04/2007)
12/03/2007	15	SECOND AMENDED complaint by Juli A. Pollitt, Michael A. Nash against Health Care Service Corporation. (gmr) (Entered: 12/07/2007)

Date Filed	No.	Docket Text
12/19/2007	16	MOTION by Defendant Health Care Service Corporation to strike *Plaintiff's Second Amended Complaint* (Witt, Helen) (Entered: 12/19/2007)
12/19/2007	18	MOTION by Defendant Health Care Service Corporation to dismiss *Plaintiff's Amended Complaint* (Witt, Helen) (Entered: 12/19/2007)
12/19/2007	19	MEMORANDUM by Health Care Service Corporation in support of motion to dismiss 18 *Plaintiff's Amended Complaint* (Witt, Helen) (Entered: 12/19/2007)
12/26/2007	21	MINUTE entry before Judge Robert W. Gettleman: Status hearing held. Plaintiffs motion 13 for leave to file second amended complaint is granted. Defendants motion 16 to strike the second amended complaint is denied. Plaintiffs response to defendants motion 18 to dismiss is due by 1/22/2008. Defendants reply is due by 2/4/2008. Status hearing continued to 3/27/2008, at 9:00 a.m. Mailed notice (mb) (Entered: 12/27/2007)

Date Filed	No.	Docket Text
12/26/2007	22	SECOND AMENDED complaint by Juli A. Pollitt, Michael A. Nash against Health Care Service Corporation. (mb,) (Entered: 12/28/2007)
01/22/2008	23	MEMORANDUM in Opposition to Defendant Health Care Service Corporation's Motion to Dismiss (Exhibits) by Juli A. Pollitt and Michael A. Nash. (Poor Quality Original - Paper Document on File.) (mb,) (Entered: 01/24/2008)
02/11/2008	27	REPLY by Health Care Service Corporation to MOTION by Defendant Health Care Service Corporation to dismiss *Plaintiff's Amended Complaint* 18 (Witt, Helen) (Entered: 02/11/2008)
04/09/2008	37	MINUTE entry before Judge Honorable Blanche M. Manning: Defendant's motion for leave to submit supplemental authority 32 is entered and continued to 4/17/2008 at 11:00 AM. Mailed notice (rth) (Entered: 04/09/2008)

Date Filed	No.	Docket Text
09/05/2008	50	MINUTE entry before the Honorable Robert W. Gettleman: Defendant's motion 18 to dismiss is granted and this matter is dismissed with prejudice. Civil case terminated. [For further detail see separate order] Mailed notice (mb) (Entered: 09/09/2008)
09/05/2008	51	ORDER Signed by the Honorable Robert W. Gettleman on 9/5/2008:(mb) (Entered: 09/09/2008)
10/02/2008	52	NOTICE of appeal by Juli A. Pollitt, Michael A. Nash regarding orders 50 , 51 Filing fee $ 455.00. (Receipt #4624009734) (dj) (Entered: 10/03/2008)
10/03/2008	56	ACKNOWLEDGEMENT of receipt of short record on appeal regarding notice of appeal 52 ; USCA Case No. 08-3509. (jj) (Entered: 10/06/2008)
03/10/2009	64	MANDATE of USCA dated 3/10/09 regarding notice of appeal 52 ; USCA No. 08-3509. The judgment of the District Court is VACATED and

Date Filed	No.	Docket Text
		REMANDED for further proceedings, in accordance with the decision of this court entered on this date. Appellants recover their costs. (mb) (Entered: 04/21/2009)
03/10/2009	65	OPINION from the USCA for the 7th Circuit; Argued 2/25/09; Decided 3/10/09 in USCA case no. 08-3509. (mb) (Entered: 04/21/2009)

U.S. Court of Appeals for the Seventh Circuit
Relevant Docket Entries for *Pollitt v. Health Care Service Corp.*, No. 08-3509

Date Filed	No.	Docket Text
10/03/2008	1	Private civil case docketed. Fee paid. Docketing statement filed. Transcript information sheet due by 10/20/2008. Appellant's brief due on or before 11/12/2008 for Michael A. Nash and Juli A. Pollitt. Record on Appeal from Northern District of Illinois, Eastern Division due by 10/24/2008. [6061237-2] [08-3509]
10/24/2008	4	Attorney Helen E. Witt for Health Care Service Corporation in 08-3509 terminated and added Attorney(s) Anthony F. Shelley for party(s) Appellee Health Care Service Corporation, in case 08-3509 per disclosure statement. Disclosure statement filed by Attorney(s) Anthony F. Shelley for party(s) Appellee Health Care Service Corporation, in case 08-3509. [08-3509]

Date Filed	No.	Docket Text
11/12/2008	5	15 copies Appellant's brief filed by Appellants Michael A. Nash and Juli A. Pollitt. Disk not required. Appellee's brief due on or before 12/12/2008 for Health Care Service Corporation. [6071506] [6071506-1] [08-3509]
12/16/2008	6	15 copies Appellee's brief filed by Appellee Health Care Service Corporation. Appellant's reply brief, if any, is due on or before 12/30/2008 for Appellant Michael A. Nash and Appellant Juli A. Pollitt [6080181] [6080181-1] Disk Filed. [08-3509]--[Edited 12/18/2008 by RS]
12/30/2008	8	15 copies Appellant's reply brief filed by Appellants Michael A. Nash and Juli A. Pollitt. [6083403] [6083403-1] Disk not required. [08-3509]
03/10/2009	10	Filed opinion of the court PER CURIAM. VACATED and REMANDED Frank H. Easterbrook, Chief Judge; Ilana Diamond Rovner, Circuit Judge and Terence T. Evans, Circuit Judge. [08-3509]

Date Filed	No.	Docket Text
03/10/2009	11	ORDER: Final judgment filed per opinion. With costs: Appellants recover their costs. [6105916-3] [08-3509]-
03/24/2009	13	Filed 30c Petition for Rehearing and Petition for Rehearing Enbanc by Appellee Health Care Service Corporation. Dist. [08-3509]
04/08/2009	15	ORDER: Appellee Health Care Service Corporation Petition for Rehearing and Petition for Rehearing Enbanc is DENIED. [6117293-1] [08-3509]
04/16/2009	16	Mandate issued with bill of costs in the amount of $564.00. Record to be returned later 1 vol. pleadings; 1 vol. loose pleadings. [08-3509]--[Edited 04/20/2009 by CD] Date updated: 04/20/2009 [08-3509]
04/16/2009		FOR COURT USE ONLY: Certified copy of 03/10/2009 Final Order with Mandate and Bill of Costs sent to the District Court Clerk. [6120081-2] [08-3509]
07/10/2009	18	Filed notice from the Supreme Court of the filing of a Petition for Writ of Certiorari. 09-38 [6169107] [08-3509]

Date Filed	No.	Docket Text
08/20/2009	17	Original record returned to the District Court. Entire record returned consisting of 1 vol. pleadings; 1 vol. loose pleadings. [08-3509]
10/19/2009	19	Filed order from the Supreme Court GRANTING the Petition for Writ of Certiorari. 09-38. [6169110-1] [08-3509]

11

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

STANDARD CONTRACT

FOR

FEE-FOR-SERVICE CARRIERS

2006

CONTRACT FOR FEDERAL EMPLOYEES HEALTH BENEFITS

CONTRACT NO: CS 1039 FULL CONTRACT

EFFECTIVE: January 1, 1960 EFFECTIVE: January 1, 2006

BETWEEN: The United States Office of Personnel Management *hereinafter called OPM, the Agency, or the Government*

Address: 1900 E Street NW
Washington, DC 20415-3610

AND

CONTRACTOR: Blue Cross and Blue Shield Association *hereinafter also called the Carrier*

Address: 1310 G Street, NW., Suite 900
Washington, DC 20005

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER	FOR THE GOVERNMENT
Stephen W. Gammarino Name of Person Authorized to Execute Contract (Type or Print)	Frank D. Titus Name of Contracting Officer (Type or Print)
Sr. Vice President, National Programs Title	Assistant Director for Insurance Services Programs Title
/s/ Stephen W. Gammarino [handwritten] 12/6/05 Date Signed	_____ Signature _____ Date Signed

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PART I - GENERAL PROVISIONS

SECTION 1.1
DEFINITIONS OF FEHB TERMS (JAN 1998)

For purpose of this contract, the following definitions apply:

FEHBP:	Federal Employees Health Benefits Program.
Enrollee:	The Federal employee, annuitant, former spouse, temporarily-covered former Federal employee or dependent, enrolled under this contract.
Member:	The Enrollee and/or an eligible dependent for benefit purposes, and sometimes referred to as subscriber.
Act:	The Federal Employees Health Benefits Act, as amended; chapter 89 of title 5, United States Code.
Regulations:	(1) The Federal Employees Health Benefits Regulations; part 890, title 5, Code of Federal Regulations, and (2) Chapters 1 and 16 of title 48, Code of Federal Regulations.
Benefits:	Covered services or payment for covered services set forth in Appendix A, to which Members are entitled to the extent provided by this contract.

Carrier:	As defined by chapter 89 of title 5, United States Code, and may be used interchangeably with the term Contractor.
Subcontractor:	Any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor, or another subcontractor, except for providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.
Letter of Credit:	The method by which certain Carriers, and their underwriters if authorized, received recurring premium payments and contingency reserve payments by drawing against a commitment (certified by a responsible OPM official) which specifies a dollar amount available. For each Carrier participating in the Letter of Credit arrangement for payment under FEHBAR 1632.170(b), the terms "carrier reserves" and "special reserves" include any balance in the Carrier's Letter of Credit account.

SECTION 1.2
ENTIRE CONTRACT (JAN 2003)

(a) This document as described in the *Table of Contents* constitutes the entire contract between the parties. No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in this contract. All

modifications to the contract must be made in writing by the duly authorized Contracting Officer.

(b) All statements concerning coverage or benefits made by OPM, the Carrier or by any individual covered under this contract shall be deemed representations and not warranties. No such statement shall convey or void any coverage, increase or reduce benefits under this contract or be used in the prosecution of or defense of a claim under this contract unless it is contained in writing and a copy of the instrument containing the statement is or has been furnished to the Member or to the person making the claim.

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SECTION 1.9
PLAN PERFORMANCE -- EXPERIENCE-RATED FFS CONTRACTS (JAN 2006)

(a) Detection of Fraud and Abuse. The Carrier shall conduct a program to assess its vulnerability to fraud and abuse and shall operate a system designed to detect and eliminate fraud and abuse internally by Carrier employees and subcontractors, by providing goods or services to FEHB Members, and by individual FEHB Members. The program must specify provisions in place for cost avoidance not just fraud detection, along with criteria for follow-up actions. The Carrier must submit to OPM an annual analysis of the costs and benefits of its fraud and abuse program. The Carrier must also submit annual reports to OPM by March 31 addressing the following: number of cases; dollars identified as lost and recovered; actual and projected

savings; cases referred by law enforcement and resolved through negotiated settlement; and number of arrests and criminal convictions. The report will also include the industry standards checklist.

(b) Clinical Care Measures. The Carrier shall measure and/or collect data on the quality of the health care services that are provided to its members as requested by OPM. Measurement/data collection efforts may include performance measurement systems developed by accrediting organizations such as the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations Organization (JCAHO), or URAC. Costs incurred by the Carrier for collecting or contracting with a vendor to collect quality measures/data shall be the Carrier's responsibility and are allowable administrative expenses, subject to the administrative cost limitation.

(c) Patient Safety. The Carrier shall implement a patient safety improvement program. At minimum, the Carrier shall --

(1) Report to OPM on its current patient safety initiatives;

(2) Report to OPM on how it will strengthen its patient safety program for the future;

(3) Assist OPM in providing its members with consumer information and education regarding patient safety; and

(4) Work with its providers, independent accrediting organizations, and others other to implement patient safety improvement programs.

(d) Accreditation. To demonstrate its commitment to providing quality, cost-effective

health care, the Carrier shall continue to pursue and maintain accreditation according to the steps and timeframes timeframe outlined in the carrier's current business plan. The carrier shall submit accreditation changes and business plan updates update to its OPM contract representative.

(e) Consumer Assessments of Health Plans Surveys (CAHPS). In addition to any other means of surveying Plan members that the Carrier may develop, the Carrier shall participate in the Health Plan Employer Data and Information Set (HEDIS) Consumer Assessments of Health Plans Surveys (CAHPS) to provide feedback to enrollees on enrollee experience with the various FEHBP plans. The Carrier shall take into account the published results of the survey, or other results as directed by OPM, in identifying areas for improvement as part of the Carrier's quality assurance program. Payment of survey charges will be in accordance with Section 3.11.

(f) Contract Quality Assurance. The Carrier shall develop and apply a quality assurance program specifying procedures for assuring contract quality. At a minimum the carrier shall meet the following standards and submit an annual report to OPM on these standards by July of the following contract period:

(1) *Claims Processing Accuracy* - the number of FEHB claims processed accurately and the total number of FEHB claims processed for the given time period, expressed as a percentage.

REQUIRED STANDARD: An average of 95 percent of FEHB claims must be processed accurately.

(2) *Claims Coding Accuracy* - the number of FEHB claims coded accurately divided by the total number of FEHB claims coded for the given time period, expressed as percentage.

REQUIRED STANDARD: An average of 98 percent of FEHB claims shall be coded accurately.

(3) *Recovery of Erroneous Payments* - the average number of working days it takes for the Carrier to begin collection action against an FEHB provider or member following identification of an erroneous payment, including overpayments.

REQUIRED STANDARD: The Carrier takes an average of no more than 30 working days from the date it identifies an FEHB erroneous payment to the date it begins the collection action.

(4) *Coordination of Benefits (COB)* - the Carrier must demonstrate that a statistically valid sampling technique is routinely used to identify FEHB claims prior to or after processing that require(d) coordination of benefits (COB) with a third party payer. As an alternative, the Carrier may provide evidence that it pursues all claims claim for COB.

(5) *Claims Timeliness* - the average number of working days from the date the Carrier receives an FEHB claim to the date it adjudicates it (paid, denied or a request for further information is sent out), for the given time period, expressed as a cumulative percentage.

REQUIRED STANDARD: The Carrier adjudicates 95 percent of claims within 30 working days.

(6) *Processing ID cards on change of plan or option* - the number of calendar days from the date the Carrier receives the enrollment from the enrollee's agency or retirement system to the date it issues the ID card.

REQUIRED STANDARD: The Carrier issues the ID card within fifteen calendar days after receiving the enrollment from the enrollee's agency or retirement system except that the Carrier will issue ID cards resulting from an open season election within fifteen calendar days or by December 15, whichever is later.

(7) *Member Inquiries* - the number of working days taken to respond to an FEHB member's written inquiry, expressed as cumulative percentage, for the given time period.

REQUIRED STANDARD: The Carrier responds to 90 percent of inquiries within 15 working days (including internet inquiries).

(8) *Telephone Access* - the Carrier shall report on the following statistics concerning telephone access to the member services department (or its equivalent) for the given time period. Except that, if the Carrier does not have computerized phone system, report results of periodic surveys on telephone access.

(i) Call Answer Timeliness - the average number of seconds elapsing before the Carrier connects a member's telephone call to its service representative.

REQUIRED STANDARD: On average, no more than 30 seconds elapse before the Carrier

connects a member's telephone call to its service representative.

(ii) Telephone Blockage Rate - the percentage of time that callers receive a busy signal when calling the Carrier.

REQUIRED STANDARD No more than 5% of callers receive busy signal.

(iii) Telephone Abandonment Rate - the number of calls attempted but not completed (presumably because callers tired of waiting to be connected to a Carrier representative) divided by the total number of calls attempted (both completed and not completed), expressed as a percentage.

REQUIRED STANDARD: On average, enrollees abandon the effort no more than 5 percent of the time.

(iv) *Initial Call Resolution* - the percentage of issues resolved during the initial call.

REQUIRED STANDARD: On average, caller's issues must be resolved during the initial call at least 60% of the time.

(9) *Responsiveness to FEHB Member Requests for Reconsideration:*

REQUIRED STANDARD: For 100 percent of written FEHB disputed claim requests received for the given time period, within 30 days after receipt by the Carrier, the Carrier shall affirm the denial in writing to the FEHB member, pay the claim, provide the service, or request additional information reasonably necessary to make a determination.

(g) Quality Assurance Plan. The Carrier must demonstrate that a statistically valid sampling

technique is routinely used prior to or after processing to randomly sample FEHB claims against Carrier quality assurance/fraud and abuse prevention standards.

(h) Reporting Compliance. The Carrier shall keep complete records of its quality assurance procedures and fraud prevention program and the results of their implementation and make them available to the Government as determined by OPM.

(i) Correction of Deficiencies. The Contracting Officer may order the correction of a deficiency in the Carrier's quality assurance program or fraud prevention program. The Carrier shall take the necessary action promptly to implement the Contracting Officer's order. If the Contracting Officer orders a modification of the Carrier's quality assurance program or fraud prevention program pursuant to this paragraph (i) after the contract year has begun, the costs incurred to correct the deficiency may be excluded from the administrative expenses -- for the contract -- year that are subject to the administrative expenses limitation specified at Appendix B; provided the Carrier demonstrates that the correction of the deficiency significantly increases the Carrier's liability under this contract.

(j) In order to allow sufficient implementation time, the Contracting Officer will notify the Carrier reasonably in advance of any new requirement(s) under paragraphs (a) through (i).

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SECTION 1.11
FEHB INSPECTION (JUL 2005) (FEHBAR 1652.246-70)

(a) The Contracting Officer, or an authorized representative of the Contracting Officer, has the right to inspect or evaluate the work performed or being performed under the contract, and the premises where the work is being performed, at all reasonable times and in a manner that will not unreasonably delay the work.

(b) The Contractor shall maintain and the Contracting Officer, or an authorized representative of the Contracting Officer, shall have the right to examine and audit all books and records relating to the contract for purposes of the Contracting Officer's determination of the Carrier's subcontractor or Large Provider's compliance with the terms of the contract, including its payment (including rebate and other financial arrangements) and performance provisions. The Contractor shall make available at its office at all reasonable times those books and records for examination and audit for the record retention period specified in the Federal Employees Health Benefits Acquisition Regulation (FEHBAR), 48 CFR 1652.204-70. This subsection is applicable to subcontract and Large Provider Agreements with the exception of those that are subject to the "Audits and Records -- Negotiation" clause, 48 CFR 52.215-2.

(c) If the Contracting Officer, or an authorized representative of the Contracting Officer, performs inspection, audit or evaluation on the premises of the Carrier, the subcontractor, or the Large Provider, the Carrier shall furnish or require the subcontractor or Large Provider to furnish all

reasonable facilities for the safe and convenient performance of these duties.

(d) The Carrier shall insert this clause, including this subsection (d), in all subcontracts for underwriting and claim payments and administrative services and in all Large Provider Agreements and shall substitute "contractor", "Large Provider," or other appropriate reference for the term "carrier."

SECTION 1.12
CORRECTION OF DEFICIENCIES (JAN 1997)

(a) The Carrier shall maintain sufficient financial resources, facilities, providers, staff and other necessary resources to meeting its obligations under this contract. If the OPM determines that the Carrier does not demonstrate the ability to meet its obligations under this contract, the OPM shall notify the Carrier of the asserted deficiencies. The Carrier agrees that, within ten (10) working days following the notification, it shall present detailed plans for correcting the deficiencies. These plans shall be presented in a form prescribed by the OPM. Pending submission or implementation of plans required under the Section, the OPM may institute action as it deems necessary to protect the interests of Members, included, but not limited to:

(1) Suspending new enrollments under this contract;

(2) Advising Enrollees of the asserted deficiencies and providing them an opportunity to transfer to another plan;

(3) Withholding payment of subscription income or restricting access to the Carrier's Letter of Credit account; or

(4) Terminating the enrollment of those Enrollees who, in the judgment of OPM, would be adversely affected by the deficiency.

(b) The Carrier agrees that failure to submit or to diligently implement plans which are required under this Section shall constitute sufficient grounds for termination of this contract pursuant to Section 1.15, *Renewal and Withdrawal of Approval.*

(c) Prior to taking action as described in paragraph (a) the OPM shall notify the Carrier and offer an opportunity to respond.

(d) The Carrier shall include the substance of this clause in the contract with its underwriter and substitute an appropriate terms for "Carrier."

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SECTION 1.15
RENEWAL AND WITHDRAWAL OF APPROVAL
(JAN 1991) (FEHBAR 1652.249-70)

(a) The contract renews automatically for a term of one (1) year each January first, unless written notice of non-renewal is given either by OPM or the Carrier not less that 60 calendar days before the renewal date, or unless modified by mutual agreement.

(b) This contract also may be terminated at other times by order of OPM pursuant to 5 U.S.C. 8902(e). After OPM notifies the Carrier of its intent

to terminate the contract, OPM may take action as it deems necessary to protect the interest of Members, including but not limited to--

(1) Suspending new enrollments under the contract;

(2) Advising Enrollees of the asserted deficiencies, and

(3) Providing Enrollees an opportunity to transfer to another plan.

(c) OPM may, after proper notice, terminate the contract at the end of the contract term if it finds that the Carrier did not have at least 300 Enrollees enrolled in its Plan at any time during the two preceding contract terms.

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PART II -- BENEFITS

SECTION 2.1
ENROLLMENT ELIGIBILITY AND EVIDENCE OF ENROLLMENT (JAN 1999)

(a) Enrollment.

(1) Each eligible individual who wishes to be enrolled in the plan offered by this Carrier shall, as a prerequisite to such enrollment, complete a Health Benefits Election Form, or use an electronic or telephonic method approved by OPM, within the time and under the conditions specified in 5 CFR Part 890. The Government personnel office having cognizance over the Enrollee shall promptly furnish notification of such election to the Carrier.

(2) A person's eligibility for coverage, effective date of enrollment, the level of benefits (option), the effective date of termination or cancellation of a person's coverage, the date any extension of a person's coverage ceases, and any continuance of benefits beyond a period of enrollment and the date any such continuance ceases, shall all be determined in accordance with regulations or directions of OPM given pursuant to chapter 89, title 5, United States Code.

(b) Special Limitations With Regard To Employee Organizations.

(1) A plan sponsored by an employee organization as defined by the Act, is available only to eligible employees, annuitants, former spouses, and former employees and dependents (and eligible members of their families) who must be or must become members of the sponsoring organization to enroll in the Plan.

(2) Employees with membership status in an employee organization at the time they become annuitants may retain their membership in the organization and, if eligible, continue their enrollment in the Plan. Survivor annuitants of Enrollees in the Plan may continue their enrollment in the Plan without becoming members of the sponsoring employee organization.

(c) The Carrier shall issue evidence of the Enrollees coverage and furnish to the Enrollee copies of any forms necessary to make claim for benefits.

SECTION 2.2
BENEFITS PROVIDED (JAN 1999)

(a) The Carrier shall provide the benefits as described in the agreed upon brochure text found in Appendix A.

(1) Benefits offered under this contract may be modified by the Carrier to permit methods of treatment not expressly provided for, but not prohibited by law, rule or Federal policy, if otherwise contractually appropriate, and if such treatment is medically necessary and is as cost effective as providing benefits to which the Member may otherwise be entitled.

(2) The Carrier may pay for or provide health service or supply in an individual case which does not come within the specific benefit provisions of the contract, if the Carrier determines the benefit is within the intent of the contract, and the Carrier determines that the provision of such benefit is in the best interests of the Federal Employees Health Benefits Program.

(3) In individual cases, the Carrier, after consultation with and concurrence by the Member and provider(s), may offer benefit alternative not ordinarily covered under this contract which will result in equally effective medical treatment at no greater cost. The decision to offer an alternative benefit is solely the Carrier's and is not subject to OPM review under the disputed claims process.

(b) In each case when the Carrier provides a non-covered benefit in accordance with the authority of (a)(1), (2) or (3) the Carrier shall document in writing prior to the provision of such benefit the reasons and justification for its determination. Such

payment or provision of services or supplies while a valid charge under the contract shall not be considered to be precedent in the disposition of similar cases.

(c) Except as provided for in (a) above the Carrier shall provide benefits for services or supplies in accordance with Appendix A.

(d) The Carrier, subject to (e) below, shall determine whether in its judgment a service or supply is medically necessary or payable under this contract.

(e) The Carrier agrees to pay for or provide a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

SECTION 2.3
PAYMENT OF BENEFITS AND PROVISION OF SERVICES AND SUPPLIES (JAN 2003)

(a) By enrolling or accepting services under this contract, Members are obligated to all terms, conditions, and provisions of this contract. The Carrier may request Members to complete reasonable forms or provide information which the Carrier may reasonably request, provided, however, that the Carrier shall not require Members to complete any form as precondition of receiving benefits unless the form has first been approved for use by OPM. Notwithstanding Section 2.9, *Claims Processing*, forms requiring specific approval do not include claim forms and other forms necessary to receive payment of individual claims.

(b) All benefits shall be paid (with appropriate documentation of payment) within a reasonable time after receipt of reasonable proof covering the occurrence, character, and extent of the event for which the claim is made. The claimant shall furnish satisfactory evidence that all services or supplies for which expenses are claimed are covered services or supplies within the meaning of the contract.

(c) The procedures and time period for filing claims shall be as specified in the agreed upon brochure text (*Appendix A*). However, failure to file claim within the time required shall not in itself invalidate or reduce any claim where timely filing was prevented by administrative operations of Government or legal incapacitation, provided the claim was submitted as soon as reasonably possible.

(d) The Carrier may request Member to submit to one or more medical examinations to determine whether benefits applied for are for services and supplies necessary for the diagnosis or treatment of an illness or injury or covered condition of the Member and may withhold payment of such benefits pending completion of the examinations. The examinations shall be made at the expense of the Carrier by a physician selected by the Member from a panel of at least three physicians whose names are furnished by the Carrier, and the result of the examinations shall be made available to the Carrier and the Member.

(e) As a condition precedent to the provision of benefits hereunder, the Carrier, to the extent reasonable and necessary and consistent with Federal law, shall be entitled to obtain from any person, organization or Government agency, including the Office of Personnel Management all

information and records relating to visits or examination of, or treatment rendered or supplies furnished to, a Member as the Carrier requires in the administration of such benefits. The Carrier may obtain from any insurance company or other organization or person any information, with respect to any Member, which it has determined is reasonably necessary to:

(1) identify enrollment in plan,

(2) verify eligibility for payment of claim for health benefits, and

(3) carry out the provisions of the contract, such as subrogation, recovery of payments made in error, workers compensation, and coordination of benefits.

(f) Benefits are payable to the Enrollee in the Plan or his or her assignees. However, under the following circumstances different payment arrangements are allowed:

(1) Reimbursement Payments for the Enrollee. If benefits become payable to the estate of an Enrollee or an Enrollee is minor, or an Enrollee is physically or mentally not competent to give valid release, the Carrier may either pay such benefits directly to a hospital or other provider of services or pay such benefits to any relative by blood or connection by marriage of the Enrollee determined by the Carrier to be equitably entitled thereto.

(2) Reimbursement Payments for a minor child. If child is covered as family member under the Enrollees self and family enrollment and is in the custody of a person other than the Enrollee, and if that other person certifies to the Carrier that he or

she has custody of and financial responsibility for the dependent child, then the Carrier may issue an identification card for the dependent child(ren) to that person and may reimburse that person for any covered medical service or supply.

(3) Reimbursement Payments to family members covered under the Enrollee's self and family enrollment. If a covered child is legally responsible, or if covered spouse is legally separated, and if the covered person does not reside with the Enrollee and certifies such conditions to the Carrier, then the Carrier may issue an identification card to the person and may reimburse that person for any covered medical service or supply. In the case of legally separated spouse, the Carrier may also furnish the explanation of benefits to the spouse when determined by the Carrier to be required.

(4) Reimbursement payments to Government programs, such as Medicaid. If Federal law provides that reimbursement is payable to Government program under coordination of benefits or similar rules, in lieu of being payable to the Enrollee or other covered person, the Carrier may reimburse the other Government program for any covered medical service or supply. To the degree that the Carrier is able to identify Medicaid beneficiaries, the Carrier will process claims directly to the provider of service or reimburse the Medicaid agency if the Medicaid agency has already paid the provider and is seeking reimbursement. When this situation is identified, the Carrier will update the member's records to ensure proper adjudication of claims.

(5) Compliance with the HIPAA Privacy Rule. The Carrier may pay benefits to covered person other than the Enrollee when in the exercise of its

discretion the Carrier decides that such action is necessary to comply with the HIPAA Privacy Rule, 45 C.F.R.§ 164.500 et seq.

(6) Any payments made in good faith in accordance with paragraphs (f)(1) through (f)(5)shall fully discharge the Carrier to the extent of such payment.

(g) *Erroneous Payments.* If the Carrier or OPM determines that a Member's claim has been paid in error for any reason (except fraud and abuse), the Carrier shall make prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider. The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall -

(1) Send a written notice of erroneous payment to the member or provider that provides: (A) an explanation of when and how the erroneous payment occurred, (B) when applicable, cite the appropriate contractual benefit provision, (C) the exact identifying information (i.e. dollar amount paid erroneously, date paid, check number, date of service and provider name), (D) a request for payment of the debt in full, and (E) an explanation of what may occur should the debt not be paid, including possible offset to future benefits. The notice may also offer an installment option. In addition the Carrier shall provide the debtor with an opportunity to dispute the existence and amount of the debt before proceeding with collection activities;

(2) After confirming that the debt does exist and in the appropriate amount, send follow-up notices to the member or the provider at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3) The Carrier may off-set future benefits payable to the member or to a provider on behalf of the member to satisfy debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice;

(4) After applying the first three steps, refer cases when it is cost effective to do so to collection attorney or collection agency if the debt is not recovered;

(5) Make prompt and diligent effort to recover erroneous payments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts;

(6) Suspend recovery efforts for a debt which is based upon claim that has been appealed as a disputed claim under Section 2.8, until the appeal has been resolved;

(7)(i) The Carrier may charge the contract for benefit payments made erroneously but in good faith provided that it can document that it acted with prompt and due diligence as described above.

(ii) Notwithstanding (g)(7)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that caused erroneous benefit payments) when the errors are egregious or

repeated. These costs are deemed to be unreasonable and unallowable under section 3.2(b)(2)(ii);

(8) Maintain records that document individual unrecovered erroneous payment collection activities for audit or future reference.

(h) Erroneous payment recoveries may be reduced by any legal or collection agency fees expended to obtain the recoveries and which are not otherwise payable under this experience-rated contract. The amount credited to the contract shall be the net amount remaining after deducting the related legal or collection agency fees.

(i) Notwithstanding subsection (f), the Carrier reserves the right to pay the Member directly for all covered services described in the agreed upon brochure text attached as Appendix A.

SECTION 2.4
TERMINATION OF COVERAGE AND
CONVERSION PRIVILEGES (JAN 1996)

(a) A Member's coverage is terminated as specified in regulation issued by OPM. Benefits after termination of coverage are as specified in the regulations.

(b) A Member is entitled to a temporary continuation of coverage or an extension of coverage under the conditions and to the extent specified in the regulations.

(c) A Member whose coverage hereunder has terminated is entitled, upon application within the time and under the conditions specified in regulations, to a non-group contract regularly offered

for the purpose of conversion from the contract or similar contracts. The conversion contract shall be in compliance with 5 U.S.C., chapter 89, and regulations issued thereunder.

(d) Costs associated with writing or providing benefits under conversion contracts shall not be an allowable cost of this contract.

(e) The Carrier shall maintain on file with OPM copies of the conversion policies offered to persons whose coverage under this contract terminates and advise OPM promptly of any changes in the policies. The Contracting Officer may waive this requirement where because of the large number of different conversion policies offered by the Carrier it would be impractical to maintain a complete up-to-date file of all policies. In this case the Carrier shall submit a representative sample of the general types of polices offered and provide copies of specific polices on demand.

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SECTION 2.8
FILING HEALTH BENEFIT CLAIMS/COURT REVIEW OF DISPUTED CLAIMS (MAR 1995)
FEHBAR 1652.204-72

(a) General. (1) The Carrier resolves claims filed under the Plan. All health benefit claims must be submitted initially to the Carrier. If the Carrier denies claim (or portion of a claim), the covered individual may ask the Carrier to reconsider its denial. If the Carrier affirms its denial or fails to respond as required by paragraph (b) of this clause, the covered individual may ask OPM to review the

claim. A covered individual must exhaust both the Carrier and OPM review processes specified in this clause before seeking judicial review of the denied claim.

(2) This clause applies to covered individuals and to other individuals or entities who are acting on the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) Time limits for reconsidering claim. (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the Carrier in which to submit a written request for reconsideration to the Carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The Carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The Carrier must simultaneously notify the covered individual of the information requested if it requests additional information from provider. The Carrier has 30 days after the date the information is received to affirm

the denial in writing to the covered individual or pay the bill or provide the service. The Carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the Carrier's notice requesting additional information. The Carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this clause if the Carrier fails to act within the time limit set forth in this paragraph.

(3) The covered individual may write to OPM and request that OPM review the Carrier's decision if the Carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this clause. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this clause.

(4) The Carrier may extend the time limit for a covered individual's submission of additional information to the Carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) Information required to process requests for reconsideration. (1) The covered individual must put the request to the Carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the Carrier needs additional information from the covered individual to make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make decision on the claim;

(iii) Specify the time limit (60 days after the date of the Carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) if this section.

(d) Carrier determinations. The Carrier must provide written notice to the covered individual of its determination. If the Carrier affirms the initial denial, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the Carrier's denial notice and include copy of the denial notice as well as documents to support the covered individual's position.

(e) OPM review. (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the Carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the Carrier's notice to the covered individual that the denial was affirmed; or

(ii) If the Carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this clause, within 120 days after the date of the covered individual's timely request for reconsideration by the Carrier; or

(iii) Within 120 days after the date the Carrier requests additional information from the covered individual, or the date the covered individual is notified that the Carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing claim denied by the Carrier, OPM may

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the Carrier, the Carrier must release the information within 30 days after the date of OPM's written

request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give written notice of its decision to the covered individual and the Carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this clause, OPM may make its decision based solely on information available to it at that time and give written notice of its decision to the covered individual and to the Carrier.

(f) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

(g) Court review. (1) A suit to compel enrollment under § 890.102 of Title 5, Code of Federal Regulations, must be brought against the employing office that made the enrollment decision.

(2) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(3) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (chapter 89, title 5, United States Code). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the Carrier or the Carrier's subcontractors.

The recovery in such a suit shall be limited to a court order directing OPM to require the Carrier to pay the amount of benefits in dispute.

(4) An action under paragraph (3) of this clause to recover on a claim for health benefits:

(i) May not be brought prior to exhaustion of the administrative remedies provided in paragraphs (a) through (f) of this clause;

(ii) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(iii) Will be limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of benefits.

* * * * *

PART III - PAYMENTS, CHARGES AND ACCOUNTING

SECTION 3.1
PAYMENTS -- EXPERIENCE-RATED CONTRACTS (JAN 2003) (FEHBAR 1652.232-71)

(A) OPM will pay to the Carrier, in full settlement of its obligations under this contract, subject to adjustment of error or fraud, the subscription charges received for the Plan by the Employees Health Benefits Fund (hereinafter called the Fund) less the amounts set aside by OPM for the Contingency Reserve and for the administrative expenses of OPM and amounts for obligations due pursuant to paragraph (b) of this clause, plus any

payments made by OPM from the Contingency Reserve.

(b) OPM will notify the Carrier of amounts due for outstanding obligations under the contract. Not later than 60 days after the date of written notice form OPM, the Carrier shall reimburse OPM. If payment is not received within the prescribed time frame, OPM shall withhold the amount due from the subscription charges owed the Carrier under paragraph (a) of this clause.

(c) The specific subscription rates, charges, allowances and limitations applicable to the contract are set forth in Appendix B.

(d) Recurring payments from premiums shall be made available for carrier drawdown not later than thirty days after receipt by the Fund. The Contracting Officer may authorize special non-recurring payments from the Contingency Reserve in accordance with OPM's regulations.

(e) In the event this contract between the Carrier an OPM is terminated or not renewed in accordance with General Provision 1.15, *Renewal and Withdrawal of Approval,* the Contingency Reserve of the Carrier held by OPM shall be available to the Carrier to pay the necessary and proper charges against this contract to the extent that the Carrier reserves are insufficient for the purpose.

SECTION 3.2
ACCOUNTING AND ALLOWABLE COST (JAN 2003) (FEHBAR 1652.216-71)

(a) Annual Accounting Statements.

(1) The Carrier shall furnish to OPM an accounting of its operations under the contract. In preparing the accounting, the Carrier shall follow the reporting requirements and statement formats prescribed by OPM in the OPM Annual and Fiscal Year Financial Reporting Instructions.

(2) The Carrier shall have its Annual Accounting Statements and that of its underwriting, if any, audited in accordance with the FEHBP Experience-Rated Carrier and Service Organization Audit Guide (Guide). The Carrier shall submit the audit report and the Annual Accounting Statements to OPM in accordance with the requirements of the Guide.

(3) Based on the results of either the independent audit prescribed by the Guide or a Government Audit, OPM may require the Carrier to adjust its annual accounting statements (i) by amounts found not to constitute actual, allowable, allocable and reasonable costs; or (ii) to reflect prior overpayments or underpayments.

(4) The Carrier shall develop corrective action plans to resolve audit findings indentified in audits that were performed in accordance with the Guide. The corrective action plans will be prepared in accordance with and as defined by the Guide.

(b) Definition of costs. (1) The Carrier may charge a cost for a contract term if the cost is actual,

allowable, allocable, and reasonable. In addition a Carrier must:

(i) on request, document and make available accounting support for the costs to justify that the cost is actual, reasonable and necessary; and

(ii) determine the cost in accordance with: (A) the terms of this contract, and (B) Subpart 31.2 of the Federal Acquisition Regulation (FAR) and Subpart 1631.2 of the Federal Employees Health Benefits Program Regulation (FEHBAR) applicable on the first day of the contract period.

(2) In the absence of specific contract terms to the contrary, the Carrier shall classify contract costs in accordance with the following criteria:

(i) Benefits. Benefit costs consist of payments made and liabilities incurred for covered health care services on behalf of FEHBP subscribers less any refunds, rebates, allowances or other credits received.

(ii) Administrative expenses. Administrative expenses consist of all actual, allowable, allocable and reasonable expenses incurred in the adjudication of subscriber benefit claims or incurred in the Carrier's overall operation of the business. Unless otherwise stated in the contract, administrative expenses include, in part: all taxes (excluding premium taxes, as provided in section 1631.205-41), insurance and reinsurance premiums, medical and dental consultants used in the adjudication process, concurrent or managed care review when not billed by a health care provider and other forms of utilization review, the cost of maintaining eligibility files, legal expenses incurred in the litigation of benefit payments and bank

charges for letters of credit. Administrative expenses exclude the cost of Carrier personnel, equipment, and facilities directly used in the delivery of health care services, which are benefit costs, and the expense of managing the FEHBP investment program which is a reduction of investment income earned.

(iii) Investment Income. While compliance with the checks presented letter of credit methodology will minimize funds on hand, the Carrier shall invest and reinvest all funds on hand, including any in the Special Reserve or any attributable to the reserve for incurred but unpaid claims, which are in excess of the funds needed to discharge promptly the obligations incurred under the contract. Investment income represents the net amount earned by the Carrier after deducting investment expenses. Investment expenses are those actual, allowable, allocable, and reasonable contract costs that are attributable to the investment of funds, such as consultant or management fees.

(iv) Other charges. (A) Mandatory statutory reserve. Charges for mandatory statutory reserves are not allowable unless specifically provided for in the contract. When the term "mandatory statutory reserve" is specifically identified as an allowable contract charge without further definition or explanation, it means a requirement imposed by State law upon the Carrier to set aside a specific amount or rate of funds into a restricted reserve that is accounted for separately from all other reserves and surpluses of the Carrier and which may be used only with the specific approval of the State official designated by law to make such approvals. The amount chargeable to the contract may not exceed

an allocable portion of the amount actually set aside. If the statutory reserve is no longer required for the purpose for which it was created, and these funds become available for the general use of the Carrier, the Carrier shall return to the FEHBP a pro rata share based upon FEHBP's contribution to the total Carrier's set aside shall be returned to the FEHBP in accordance with FAR 31.201-5.

(B) Premium taxes. (1) When the term "premium taxes" is used in this contract without further definition or explanation, it means a tax, fee, or other monetary payment directly or indirectly imposed on FEHB premiums by any State, the District of Columbia, or the Commonwealth of Puerto Rico or by any political subdivision or other governmental authority of those entities, with the sole exception of a tax on net income or profit, if that tax, fee, or payment is applicable to a broad range of business activity.

(2) For purposes of this paragraph (B), OPM has determined that the term "State" as used in 5 U.S.C. 8909(f) includes, but is not limited to, a territory or possession of the United States.

(c) Certification of Accounting Statement Accuracy. (1) The Carrier shall certify the annual and fiscal year accounting statements in the form set forth in paragraph (c)(3) of this clause. The Carrier's chief executive officer and the chief financial officer shall sign the certificate.

(2) The Carrier shall require an authorized agent of its underwriting, if any, also to certify the annual accounting statement.

(3) The certificate required shall be in the following form:

CERTIFICATION OF ACCOUNTING STATEMENT ACCURACY

This is to certify that I have reviewed this accounting statement and to the best of my knowledge and belief:

1. The statement was prepared in conformity with the guidelines issued by the Office of Personnel Management and fairly presents the financial results of this reporting period in conformity with those guidelines.

2. The costs included in the statement are actual, allowable, allocable, and reasonable in accordance with the terms of the contract and with the cost principles of the Federal Employees Health Benefits Acquisition Regulation and the Federal Acquisition Regulation;

3. Income, rebates, allowances, refunds and other credits made or owed in accordance with the terms of the contract and applicable cost principles have been included in the statement;

4. If applicable, the letter of credit account was managed in accordance with 5 CFR part 890, 48 CFR chapter 16, and OPM guidelines.

Carrier Name:

_____

Name of Chief Executive Officer:
(Type or Print)

_____

Name of Chief Financial Officer:

_____

Signature of Chief Executive Officer:

_____

Signature of Chief Financial Officer:

_____

Date Signed: _____

Date Signed: _____

Underwriter:

_____

Name and Title of Responsible Corporate Official:
(Type or Print)

_____

Signature of Responsible Corporate Official:

_____

Date Signed: _____

(End of Certificate)

* * * * *

SECTION 3.7
SERVICE CHARGE (JAN 1996)

(a) Any service charge negotiated shall be set forth in Appendix B and shall be the total profit that can be charged to the contract. The amount set for in Appendix B shall encompass all profit (whether entitled to service charge, profit, fee, contribution to reserves or surpluses or any other title) that may be included in major subcontracts in accordance with the provisions of FEHBAR 1631.205-80, Major Subcontractor Service Charges.

(b) One-twelfth of the service charge for the contract terms accrues on the last day of each month during the contract term. The Carrier shall withdraw the service charge from the Special Reserve when it accrues.

(c) If this contract is renewed by operation of section 1.15(a), the amount of the service charge accrued under (b) shall be "one-twenty-fourth" rather than "one-twelfth." The remainder of the service charge not otherwise accrued during the contract term shall accrue on the last day of the contract term.

* * * * *

SECTION 4.3
DEFINITION OF CARRIER (JAN 1991)

The Carrier is the Blue Cross and Blue Shield Association, an Illinois not-for-profit corporation, acting on behalf of participating Blue Cross and Blue Shield Plans and pursuant to authority specified in

Exhibit A for and in behalf of the organizations specified in Exhibit A (hereinafter sometimes referred to as "Participating Plans").

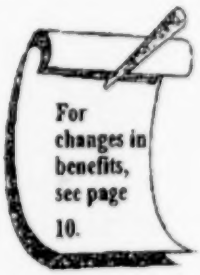
* * * * *

Blue Cross® and Blue Shield®
Service Benefit Plan

http://www.fepblue.org

2007

A fee-for-service plan (standard and basic option) with a preferred provider organization



Sponsored and administered by: The Blue Cross and Blue Shield Association and participating Blue Cross and Blue Shield Plans

Who may enroll in this Plan. All Federal employees and annuitants who are eligible to enroll in the FEHB

Enrollment codes for this Plan:

104 Standard Option - Self Only
105 Standard Option - Self and Family
111 Basic Option - Self Only
112 Basic Option - Self and Family

ACCREDITED
CASE MANAGEMENT

ACCREDITED
CASE MANAGEMENT

This Plan has Health Web Site and Case Management accreditation from URAC. See the 2007 FEHB Guide for more information on accreditation.

Federal Employees Health Benefits Program

Authorized for distribution by the

United States
Office of Personnel Management

Center for
Retirement and Insurance Services
http://www.opm.gov/insure

71-005

* * * * *

Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan** under our contract (CS 1039) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by participating Blue Cross and Blue Shield Plans (Local Plans) that administer this Plan on behalf of the Blue Cross and Blue Shield Association (the Carrier). The address for the Blue Cross and Blue Shield Service Benefit Plan administrative office is:

Blue Cross and Blue Shield Service Benefit Plan
1310 G Street, NW, Suite 900
Washington, DC 20005

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health care benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 8. Rates are shown on the back cover of this brochure.

* * * * *

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for precertification or prior approval required by Section 3:

Step	Description
1	Ask us in writing to reconsider our initial decision. Write to us at the address shown on your explanation of benefits (EOB) form. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program or Mail Service Prescription Drug Program); and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we

receive your request to:

a) Pay the claim (or, if applicable, precertify your hospital stay or grant your request for prior approval for a service, drug, or supply); or

b) Write to you and maintain our denial – go to step 4; or

c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.

3 You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

4 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

• 90 days after the date of our letter upholding our initial decision; or

• 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or

• 120 days after we asked for additional information – if we did not send you a

decision within 30 days after we received the additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 1, 1900 E Street, NW, Washington, DC 20415-3610.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent

with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claims decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your

lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

a) We have not responded yet to your initial claims or request for precertification/prior approval, then call us at the customer service number on the back of your Service Benefit Plan ID card and we will expedite our review; or

b) We denied your initial claim or request for precertification/prior approval, then:

•If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or

•You may call OPM's Health Insurance Group 1 at 1-202-606-0727 between 8 a.m. and 5 p.m. eastern time.

* * * * *

Section 11 FEHB Facts

Coverage information

• No pre-existing condition limitation	We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the

condition before you enrolled.

• Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next Open Season for enrollment begins.

We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

• Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment

form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

• Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your

children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;

- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or

- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self

Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/ administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

• When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2006

benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

· When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

· When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

·Your enrollment ends, unless you cancel your enrollment, or

·You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to

continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage, or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

• Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

•Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

• Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (if you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

· Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health-related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program.* See also the FEHB Web site at www.opm.gov/insure/ health; and refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the

requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

* * * * *

IN THE CIRCUIT COURT OF THE NINETEENTH JUDICIAL CIRCUIT LAKE COUNTY, ILLINOIS

Juli A. Pollitt and Michael A. Nash	)	
Plaintiffs	)	No. 07 L709
vs.	)	
	)	At Law
	)	
HealthCare Service Corporation	)	
	)	[FILED SEP 10 2007
Defendant	)	/s/ Circuit Clerk]

COMPLAINT

Plaintiffs, Juli A. Pollitt and Michael A. Nash, the parents of minor child Michael F. Pollitt, complain of Defendant, Health Care Service Corporation, and state as follows:

1. Because Defendant is an insurance company doing business in Illinois and because many of the actions referred to in this complaint took place in Lake County Illinois, venue is proper in the Circuit Court of that county.

2. From June of 1993 to July of 2007 Plaintiff Juli A. Pollitt paid premiums to Defendant under the terms of medical insurance policy #FEP00-[ID Number omitted], covering both herself and her minor child, Michael F. Pollitt, and submitted claims to Defendant for all of the medical expenses of both herself and her minor child, Michael F. Pollitt.

3. At no time has Plaintiff Juli A. Pollitt authorized any change in the policy of medical

insurance provided by Defendant, #FEP00-[ID Number omitted] that would have removed her minor child, Michael F. Pollitt from coverage.

[Court stamp omitted]

4. From June of 1993 to July 2007 Defendant paid all medical insurance claims for both Juli A. Pollitt and her minor child, Michael F. Pollitt.

5. At no time from June 13, 1993 to July 30, 2007 did Plaintiffs receive any notice from Defendant or any other party, or any other indication sufficient to alert them that there had been any change in the insured status of their minor child, Michael F. Pollitt.

6. Plaintiffs, relying on the conduct, representations and statements of Defendant in accepting premiums and paying medical insurance claims for both Juli A. Pollitt and Michael F. Pollitt, and believing both to be properly insured for medical expenses, refrained from procuring other medical insurance for either party.

7. Plaintiff Juli A. Pollitt, in continuing to pay premiums under policy #FEP00-[ID Number omitted], and continuing to submit claims for both herself and her minor child, Michael F. Pollitt, put Defendant on notice of this reliance.

8. The period of time, nearly four years, during which Defendant paid what it later deemed to be improper claims for Michael F. Pollitt, was too long to be considered the result of a reasonable mistake.

9. By reason of the facts herein set forth, Defendant is estopped from denying Plaintiffs' minor child, Michael F. Pollitt, was covered under Defendant's policy of medical insurance, #FEP00-[ID

Number omitted], for any period of time between June 13, 1993 and July 30, 2007.

10. On July 30, 2007 Defendant informed Plaintiffs for the first time that there was no medical insurance coverage for their minor child Michael F. Pollitt, but gave no indication as to why that was the case and no indication of any actions that it planned to take as a result.

11. On July 31, 2007 Defendant sent notices to 10 medical service providers for Michael F. Pollitt, informing them that payments it had made to them had been made in error and would have to be returned.

12. In bad faith, intentionally and with willful and wanton disregard for Plaintiffs' rights, Defendant gave Plaintiffs no prior notice of the above mentioned actions and no opportunity either to appeal them or to offer any compromise resolution of the matter, either before or after those actions were taken.

13. On August 1, 2007 Plaintiff Juli A. Pollitt received an ID card from Defendant, attached to a letter indicating that this was her "new" card and that it reflected changes that she had "recently" made in her enrollment. The letter was dated only by reference to the date on the card, October 3, 2003, and, by its language, gave the appearance of having been produced on or about that date.

14. In bad faith, intentionally and with willful and wanton disregard for Plaintiffs' rights, Defendant issued the backdated correspondence mentioned above in order to create the impression that Plaintiffs had been notified of a change in the medical insurance coverage for their minor child,

Michael F. Pollitt, nearly four years before they were actually notified.

15. In bad faith, intentionally and with willful and wanton disregard for Plaintiffs' rights, Defendant has attempted to make Plaintiffs suffer the consequences of its own mistakes.

16. As a result of the intentional, willful and wanton acts of Defendant, Plaintiffs will now be held accountable for nearly four years of uninsured medical expenses for their minor child, Michael F. Pollitt.

17. As a result of the intentional, willful and wanton acts of Defendant, Plaintiffs have experienced severe mental suffering and emotional distress, and were publicly humiliated in their community.

18. These injuries to Plaintiffs were readily foreseeable from Defendant's actions.

19. Since July of 2007, Plaintiff Juli F. Pollitt, has repeatedly contacted Defendant and demanded that it honor the terms of its insurance #FEP00-[ID Number omitted] and that it cease all actions to recover money paid to the medical service providers for her minor child, Michael F. Pollitt.

20. Plaintiffs are ready and willing to do whatever is required, in order to continue to receive medical insurance coverage for their minor child, Michael F. Pollitt, from Defendant.

Wherefore, Plaintiffs pray that this Court grant the following relief:

A. Grant plaintiffs' demand for a jury for the trial of this cause of action.

B. Enter judgment for Plaintiffs and against Defendant, directing Defendant to honor all medical insurance claims for their minor child, Michael F. Pollitt, for the period of time from June 16, 1993 to July 30, 2007.

C. Enter judgment for Plaintiffs and against Defendant, directing Defendant to cease all actions to secure the return of money paid to medical services providers for Plaintiffs' minor child, Michael F. Pollitt.

D. Enter judgment for Plaintiffs and against Defendant, directing Defendant to provide medical insurance coverage for Plaintiffs' minor child, Michael F. Pollitt, from July 31, 2007 until such time as either he reaches 21 years of age or Plaintiff Juli A. Pollitt chooses to remove him from her policy.

E. Award to Plaintiffs, as compensatory damages, an amount of money equal to the total amounts collected from or requested from medical service providers for their minor child, Michael F. Pollitt, amounts for which Plaintiffs have become or will become liable.

F. Award to Plaintiffs the sum of $2,000,000, in compensatory damages for their mental suffering, emotional distress and public humiliation arising from the intentional, willful and wanton acts of Defendant.

G. Award to plaintiffs the sum of $10,000,000, in punitive damages for the bad faith displayed by Defendant in committing its intentional, willful and wanton acts.

H. Award to Plaintiffs the costs of this suit and such other damages, as the court shall deem appropriate.

I. Award to Plaintiffs an amount equal to 10% per year of all damages awarded in this suit, compounded daily from the date this complaint was filed.

Verifications:

State of Illinois)
)
County of Lake) **SS**

Juli A. Pollitt, being sworn, states that she is the plaintiff in the above entitled case, that she has knowledge of the facts pleaded in the foregoing complaint, and that those facts are true.

/s/
Juli A. Pollitt
912 W. Grove Avenue
Waukegan, Illinois 60085
847-672-6450

State of Illinois)
)
County of Lake) **SS**

Michael A. Nash, being sworn, states that he is the plaintiff in the above entitled case, that he has

knowledge of the facts pleaded in the foregoing complaint, and that those facts are true.

/s/

Michael A. Nash
12538 W. Bairstow Avenue
Beach Park, IL 60087
847-263-9504

October 17, 2007

Juli A. Pollitt
912 W. Grove Ave.
Waukegan, IL 60085-1853

Patient: Michael Pollitt
Subscriber Number: [ID Number omitted]
Inquiry Number: I7-260-002
Dates of Service: see attached charts
Claim Number: see attached charts

Dear Ms. Pollitt:

Your correspondence requesting reconsideration of the Plan's refund requests for the services received from October 18, 2003 - present, from Dr. Goldberg, Dr. Attar, and Children's Therapy and Rehab, was recently received.

Today we received information that is being reinstated on your insurance policy and the premium issue will be discussed with you by the Office of Worker's Compensation. This means that we will be able to rescind the refund requested noted in the attached charts.

Thank you for giving us an opportunity to address your concerns. If you have any questions additional questions [sic], feel free to contact me directly at 1-325-793-4369.

Sincerely,

Carrie Cadena

Carrie Cadena
Reconsideration Specialist
Blue Cross Blue Shield of Illinois

IN THE UNTED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS

JULI A. POLLITT and MICHAEL A. NASH, *Plaintiffs,*	)
v.	) No. 07 CV 5961) Judge Gettleman) Magistrate Judge Keys
HEALTH CARE SERVICE CORPORATION, *Defendant.*	)

NOTICE OF REMOVAL

Defendant Health Care Service Corporation ("HCSC"), an Illinois mutual legal reserve company, respectfully files this Notice of Removal and states as follows:

INTRODUCTION

1. Plaintiffs Juli A. Pollitt and Michael A. Nash filed a complaint against HCSC in the Circuit Court for the Nineteenth Judicial Circuit, Lake County, Illinois, Case No. 07 L 709. HCSC first became aware of this action when it was served with a summons and the complaint on or after September 20, 2007. Pursuant to 28 U.S.C. § 1446(a), HCSC has attached copies of all process, pleadings, or orders served on it at Exhibit A.

2. HCSC is removing this action within the 30-day time period authorized in 28 U.S.C. § 1446(b).

3. HCSC removes this action on the following bases: (1) pursuant to 28 U.S.C. § 1441 as an action over which this Court has federal question jurisdiction under 28 U.S.C. § 1331; and (2) pursuant to 28 U.S.C. § 1442(a)(1), which permits removal where a person acting under the direction of a federal agency and its officers is sued for actions taken under color of federal office.

NATURE OF THE CASE

4. Plaintiff Juli A. Pollitt is an enrollee in the Service Benefit Plan (or "the Plan"), a health benefits plan for federal employees, annuitants, and their dependents. *See* Declaration of Stacy Anthony ¶ 4 (Exh. B) [hereinafter "Anthony Decl."]. Plaintiffs' suit against HCSC involves alleged denials of benefits associated with enrollment of their minor son as a dependent on Ms. Pollitt's Plan coverage. *See* Compl. ¶¶ 2-20 (Exh. A).

5. The Service Benefit Plan was created by a federal government contract between the United States Office of Personnel Management ("OPM") and the Blue Cross and Blue Shield Association ("Association"), pursuant to the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-8914. *See generally* 2006 Service Benefit Plan Master Contract & 2007 amendment (Exhs. C & D). In signing the contract, the Association acts on behalf of local Blue Cross and Blue Shield Plans, which administer the Plan in their localities. HCSC, which does business in Illinois as Blue Cross Blue Shield of Illinois, administers the Plan in Illinois.

6. FEHBA and the regulations implementing it (promulgated by OPM) establish a comprehensive framework for the supervision and

administration of FEHBA plans, including a process for contesting denials of benefits and services.

a. FEHBA authorizes OPM to contract for the provision of health plans, to determine the benefit structure of each plan, and to promulgate the official description of a plan's terms in a Statement of Benefits. *See* 5 U.S.C. §§ 8902(a), 8902(d), 8907. The government contract between OPM and the Association incorporates this Statement of Benefits. 2006 Service Benefit Plan Master Contract § 2.2(a) (Exh. C); *see* 2007 Statement of Benefits for the Service Benefit Plan at 4 (Exh. E).

b. The federal government subsidizes the Service Benefit Plan, and the funds to pay benefits are held in the U.S. Treasury. *See* 5 U.S.C. §§ 8906, 8909.

c. OPM and the individual federal agencies employing particular enrollees are responsible for all enrollment determinations associated with the Plan, and OPM's regulations provide that "[a] suit to compel enrollment . . . must be brought against the employing office that made the enrollment decision." 5 C.F.R. § 890.107(a); *see also* 2006 Service Benefit Plan Master Contract § 2.1 (Exh. C) ("A person's eligibility for coverage, effective date of enrollment, the level of benefits (option), the effective date of termination or cancellation of a person's coverage, the date any extension of a person's coverage ceases, and any continuance ceases, shall all be determined in accordance with regulations or directions of OPM given pursuant to [FEHBA]."); *see generally* 5 C.F.R. § 890.102.

d. Congress vested in OPM the exclusive authority to police the conduct and practices of FEHBA carriers, and the agency has promulgated extensive regulations on the topic. *See* 5 U.S.C. §§ 8902(e), 8910, 8913(a); 48 C.F.R. Chapter 16; *see also Kight v. Kaiser Found. Health Plans of the Mid-Atlantic States, Inc.*, 34 F. Supp. 2d. 334, 342 (E.D. Va. 1999); *Bridges v. Blue Cross & Blue Shield Ass'n*, 935 F. Supp. 34, 42-43 (D.D.C. 1996).

e. FEHBA, OPM's regulations, and the OPM-Association cont[r]act (including the Statement of Benefits) establish that the exclusive remedy for grievances regarding benefits is an administrative appeal at OPM, followed by judicial review of OPM's decision. OPM prohibits lawsuits against a FEHBA carrier or its subcontractors relating to the provision of benefits under a FEHBA plan. *See* 5 U.S.C. §§ 8902(j), 8912; 5 C.F.R. §§ 890.105, 890.107; 2007 Statement of Benefits at 97-98 (Exh. E).

f. FEHBA contains a preemption provision that states: "The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1) (2000) (as amended by the Federal Employees Health Care Protection Act of 1998, Pub. L. No. 105-266, § 3(c), 112 Stat. 2363, 2366 (1998)). The provision's purpose is to ensure nationwide uniformity in the administration of benefits. *See* H. Rep. No. 105-374, at 9, 16 (1997).

7. In this action, Plaintiffs assert that their minor child was wrongfully excluded from enrollment as a dependent under Ms. Pollitt's coverage in the Plan, that benefits for him have been and are being wrongfully denied, and that HCSC acted purportedly in bad faith in administering Ms. Pollitt's enrollment and benefits. *See* Compl. ¶¶ 2-20 (Exh. A). Plaintiffs sue to compel enrollment of the dependent retroactively, for benefits otherwise denied, and $12 million in compensatory and punitive damages. *See id.* at "Wherefore" clause.

8. The central grievance alleged in the complaint is that Plaintiffs' son was removed from the Plan's enrollment retroactively and that the Plan, as a result, took steps to re-collect benefits payments that previously had been made on behalf of Plaintiffs' son. *See id.* ¶¶ 10-14. In reality, because the government is responsible for and controls enrollment, any actions of the sort about which Plaintiffs complain were at the direction of the government. The Plan received direction earlier this year from the government to retroactively change Ms. Pollitt's coverage from "Family" to "Self-only." *See* Anthony Decl. ¶ 7. The government has recently informed the Plan that the retroactive change the government earlier instructed should be rescinded and that Plaintiffs' son shall be retroactively reinstated in the Plan. *See id.* ¶¶ 8-9. HCSC recently informed Ms. Pollitt that her son has been reinstated in the Plan and that it will rescind any refund requests concerning earlier benefits paid on her son's behalf. *See* Ltr. from HCSC to Ms. Pollitt (Oct. 17, 2007) (Exh. F).

GROUNDS FOR REMOVAL

9. This case is also removable pursuant to 28 U.S.C. § 1441 based on federal question jurisdiction existing under 28 U.S.C. § 1331. The Court has federal question jurisdiction – and thus removal jurisdiction – on each of the following independent bases:

a. FEHBA's enforcement scheme provides the exclusive remedy for all disputes involving the denial of benefits and the administration of benefits under a FEHBA plan. On this basis, Plaintiff's claims are "completely preempted" by FEHBA and are removable. *See, e.g., McCoy v. Unicare Life & Health Ins. Co.*, 2007 U.S. Dist. LEXIS 20798, at *12-*15 (N.D. Ill. Oct. 18, 2004); *Doyle v. Blue Cross Blue Shield of Ill.*, 149 F. Supp. 2d 427, 433-34 (N.D. Ill. 2001); *see also Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 399 (9th Cir. 2002); *Center for Restorative Breast Surgery, LLC v. Blue Cross Blue Shield of La.*, 2007 U.S. Dist. LEXIS 34833, *27-*29 (E.D. La. May 10, 2007); *Alabama Dental Ass'n v. Blue Cross & Blue Shield of Ala.*, 2007 U.S. Dist. LEXIS 685, at *16-*21 (M.D. Ala. Jan. 3, 2007); *St. Mary's Hospital v. CareFirst of Maryland, Inc.*, 192 F. Supp. 2d 384, 388-89 (D. Md. 2002); *Carter v. Blue Cross & Blue Shield of Fla., Inc.*, 61 F. Supp. 2d 1237, 1244 & n.2 (N.D. Fla. 1998); *Rievley v. Blue Cross & Blue Shield of Tenn.*, 69 F. Supp. 2d 1028, 1035-37 (E.D. Tenn. 1999); *Kight v. Kaiser Found. Health Plan of the Mid-Atlantic States, Inc.*, 34 F. Supp. 2d 334, 338-40 (E.D. Va. 1999); *cf. Empire HealthChoice Assurance, Inc. v. McVeigh*, 126 S. Ct. 2121, 2134 (2006) (FEHBA's "prescriptions ensur[e] that suits brought by beneficiaries for denial of benefits will land in

federal court") (internal quotation marks omitted); *see generally Beneficial Nat'l Bank v. Anderson*, 539 U.S. 1 (2003) (setting general standards for complete preemption).

b. Federal law likewise provides the exclusive enforcement mechanism where a party seeks to compel enrollment in a FEHBA plan. On this basis as well, Plaintiffs' claims are completely preempted by federal law. *See* 5 C.F.R. § 890.107(a); 5 U.S.C. § 706.

c. Suits challenging the administration of FEHBA plans and benefits are governed exclusively by FEHBA, its regulations, and federal common law and therefore raise federal questions. Federal common law controls actions in which the application of state law significantly conflicts with federal interests and policy; and the application of state remedies in the context of FEHBA disputes involving benefits and enrollment significantly conflicts with FEHBA's remedial scheme, OPM's and employing federal agencies' authority, and Congress's desire for uniformity in the administration of FEHBA benefits. *See Kight*, 34 F. Supp. 2d at 341; *Rievley*, 69 F. Supp. 2d at 1037; *cf. Empire*, 126 S. Ct. at 2131-33 (re-affirming application of federal common law where there is significant conflict between the operation of state law and federal policy); *Blue Cross Blue Shield of Ill. v. Cruz*, 495 F.3d 510, 513 (7th Cir. 2007) (holding that federal common law does not control FEHBA subrogation disputes, but indicating that FEHBA benefits matters do call for the application of federal common law).

d. Plaintiffs' claims raise federal questions because they artfully pled state law claims in a federal field that has extinguished the state law

bases on which Plaintiffs rest. *See Cahnmann v. Sprint Corp.*, 133 F.3d 484, 490 (7th Cir. 1998) (artful pleading doctrine).

10. This case is removable pursuant to 28 U.S.C. § 1442(a)(1), because HCSC is acting under the direction of a federal agency and its officers and was sued for actions taken under color of federal office.

a. 28 U.S.C. § 1442(a)(1) authorizes removal of an action against "[a]ny officer of the United States or any agency thereof, or person acting under him, for any act under color of such office." As the statutory language imparts, "the reach of section 1442(a)(1) extends to private persons . . . who act under the direction of federal officers." *Camacho v. Autoridad de Telefonos de Puerto Rico*, 868 F.2d 482, 486 (1st Cir. 1989); *see also Watson v. Philip Morris Cos.*, 127 S. Ct. 2301 (2007). Moreover, "[t]he words 'acting under' are broad, and [the Supreme Court] has made clear that the statute must be 'liberally construed.'" *Watson*, 127 S. Ct. at 2304-05.

b. As pertinent to 28 U.S.C. § 1442(a)(1), Plaintiffs are seeking relief against HCSC in connection with actions taken under the direction of a federal agency and federal officers. A defendant is deemed to be sued for actions under the direction of a federal agency and federal officers where a plaintiff sues him in connection with actions taken in the course of administering a federal program over which a federal agency and its officers have comprehensive and detailed control or supervision. *See, e.g., Anesthesiology Assocs. of Tallahassee, P.A. v. Blue Cross & Blue Shield of Fla.*, No. 03-15664, slip op. at 3-5 (11th Cir. Mar. 18,

2005) (holding that Blue Cross Blue Shield entity administering FEHBA plan properly invoked section 1442(a)(1) to remove claim) (Exh. G); *Ala. Dental Ass'n, v. Blue Cross & Blue Shield of Ala., Inc.*, 2007 U.S. Dist. LEXIS 685, at *21-*25 (M.D. Ala. January 3, 2007) (same); *accord Peterson v. Blue Cross/Blue Shield of Tex.*, 508 F.2d 55, 56-57 (5th Cir. 1975) (holding that Blue Cross Blue Shield entities administering Medicare plan properly removed claim brought by provider, pursuant to section 1442(a)(1)); *Group Health, Inc. v. Blue Cross Ass'n*, 587 F. Supp. 887, 891 (S.D.N.Y. 1984) (same); *Holton v. Blue Cross & Blue Shield of S.C.*, 56 F. Supp. 2d 1347, 1351-52 (M.D. Ala. 1999) (holding that Blue Cross Blue Shield entity administering health benefits plan for dependents of military retirees properly removed case pursuant to section 1442(a)(1)); *see generally Watson*, 127 S. Ct. at 2308 (indicating that federal government contractors have right to remove when assisting federal officers and agencies).

c. Here, Plaintiff is suing HCSC to challenge enrollment and benefits determinations. HCSC's actions are subject to the comprehensive control and oversight of a federal agency, OPM. Indeed, enrollment is a matter for which the government is solely responsible, and the government issues directions as to who shall be enrolled and when the enrollment shall take effect. HCSC's actions in treating Plaintiffs' son as dis-enrolled were as a result of express direction by the government concerning Ms. Pollitt's enrollment. *See supra* ¶ 8. Likewise, through its administrative appeals process, OPM issues the final directive with respect to the payment of disputed benefits. On this basis, Plaintiffs' allegations are causally connected to HCSC's actions under the direction of a federal agency and its officers.

d. Also consistent with the requirements of 28 U.S.C. § 1442(a)(1), there are colorable federal defenses to Plaintiffs' claims. HCSC has a colorable defense of preemption, because 5 U.S.C. § 8902(m)(1) provides that no claims may be pursued under state law that relate to a FEHBA plan's benefits or administration. *See McCoy*, 2007 U.S. Dist. LEXIS 20798, at *12-*15; *see also Botsford*, 314 F.3d at 393-96; *Burkey v. Gov't Employees Hosp. Ass'n*, 983 F.2d 656, 660 (5th Cir. 1993); *Hayes v. Prudential Ins. Co. of Am., Inc.*, 819 F.2d 921, 926 (9th Cir. 1987); *Myers v. United States*, 767 F.2d 1072, 1074 (4th Cir. 1985); *St. Mary's Hosp.*, 192 F. Supp. 2d at 388-89, 390; *Kight*, 34 F. Supp. 2d at 342; *Carter*, 61 F. Supp. 2d at 1243; *Negron v. Patel*, 6 F. Supp. 2d 366, 370 (E.D. Pa. 1998); *Robinson v. Humana Group Health Plan*, 1996 U.S. Dist. LEXIS 16578, at *14-*20 (D.D.C. Nov. 4, 1996). Additionally, HCSC has colorable defenses of official and sovereign immunity on the grounds that Plaintiff is here suing a party acting under color of federal authority for actions taken in the course of its federal duties, and Plaintiffs' case implicates funds in the U.S. Treasury, making the United States the real party in interest. *See Shands v. Beech St. Corp.*, 208 F.3d 1308, 1311-13 (11th Cir. 2000) (finding contractor administering health benefits plan for state government employees immune from suit over benefits); *see also Matranga v. Travelers Ins. Co.*, 563 F.2d 677, 677 (5th Cir. 1977); *Pani v. Empire Blue Cross Blue Shield*, 152 F.3d 67, 74 (2d Cir. 1998); *Pine View Gardens, Inc. v. Mutual of Omaha Ins. Co.*, 485 F.2d 1073, 1074-75 (D.C. Cir. 1973).

11. Pursuant to 28 U.S.C. § 1446(d), HCSC promptly will provide written notice of this removal

to the Circuit Court for Lake County and to all adverse parties.

WHEREFORE, HCSC removes this action from the Circuit Court of Lake County, Illinois.

Dated: October 22, 2007

Respectfully submitted,

/s/

Helen E. Witt, P.C.
KIRKLAND & ELLIS LLP
200 East Randolph Drive
Chicago, IL 60601
Telephone: (312) 861-2148
Facsimile: (312) 861-2200
E-mail:
hwitt@chicago.kirkland.com

Counsel for Defendant Health Care Service Corporation

Of counsel:

Anthony F. Shelley
MILLER & CHEVALIER CHARTERED
655 Fifteenth Street NW, Suite 900
Washington, DC 2005
Telephone: (202) 626-5800
Facsimile: (202) 626-0858
E-mail: ashelley@milchev.com

[Certificate of Service omitted]

DECLARATION OF STACY ANTHONY

I, Stacy Anthony, declare as follows:

1. I am employed as Consultant, Member Services, by the Blue Cross and Blue Shield Association, Federal Employee Program ("FEP"), in Washington, D.C.

2. In that capacity, I handle member inquiries and issues associated with disputed claims under the Service Benefit Plan, which is one of the federal government's health benefits plans for federal employees and their dependents.

3. As Consultant, Member Services, for FEP, I have access to the enrollment and claims payment records of those individuals enrolled in the Service Benefit Plan. Enrollment is handled by the employing federal agency and the U.S. Office of Personnel Management, and our enrollment records reflect the directions that those federal agencies provide to FEP.

4. I have reviewed the enrollment records for the Service Benefit Plan, and they establish that Juli A. Pollitt has been enrolled in the Service Benefit Plan from May 10, 1987 to the present.

5. These enrollment records also establish that, when Ms. Pollitt first enrolled in the Service Benefit Plan in 1987, she enrolled in Self-only coverage. Exhibit 1 is a print-out of enrollment status information from FEP's systems, and it indicates that from May 10, 1987 to June 13, 1993, Ms. Pollitt was

enrolled in "Enroll Code 104," which is Self-only coverage.

6. The enrollment records further establish that, as of June 13, 1993, Ms. Pollitt switched her enrollment to "Enroll Code 105," which is Self and Family Coverage. *See also* Exh. 1.

7. As reflected in Exhibit 2, which is a print-out of the response of the U.S. Department of Labor ("DOL") to an earlier FEP enrollment reconciliation report, the DOL instructed FEP on approximately July 18, 2007 to change Ms. Pollitt's enrollment back to "Enrollment Code 104" or Self-only coverage from the date "10-19-03."

8. On October 3, 2007, I received a copy of a letter dated September 18, 2007 (attached here as Exhibit 3) from the U.S. Department of Energy ("DOE") to the DOL indicating that, in 2004, Ms. Pollitt transferred from the "rolls" of the DOE to the DOL. The letter indicates that Ms. Pollitt was enrolled in "105" or Self and Family coverage at the time of the transfer and that this coverage "should have continued" upon the transfer. The DOE indicated in the letter that it was sending the letter to the DOL "to effect this correction."

9. As noted in Exhibit 4, FEP received from the DOL a "Notice of Change in Health Benefits Enrollment" dated October 5, 2007 indicating that Ms. Pollitt should be placed in "Enrollment code number 105," to be effective retroactively to "08/20/2004."

10. As of the date of this declaration, FEP's records reflect that Ms. Pollitt has had Self and Family coverage since June 13, 1993.

11. Exhibits 1, 2, and 4 to this declaration have been redacted to remove certain personal identifiers (such as phone numbers, dates of birth, and social security numbers).

I declare under penalty of perjury that the foregoing is true and correct.

/s/
Stacy Anthony

Signed on October 22, 2007

FEPDirect Re

NEWS HELP

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contract search
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mhsa treatment plans
refunds
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medicare fee
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enrollment info

Quick Search | Ex

Summary

Contract Summary | Contract Enrollment | Member Roster

Contract ID: [redacted] Last Name: POLLITT

Contract Summary

JULI A. POLLITT
912 W GROVE AVE

WAUKEGAN, IL 60085-1853

Home: [redacted]
Work:
Email:
Source: S - MERKLE
Proc Date: 04/20/2004

Special Info:
Inventory Claims:
Denied w/in 3 year
Approved
Active
MHSA:
Refunds:

Alternate Address

Home:
Effective Date:
Term Date:
Source:
Proc Date:

SSN: [redacted]
CSA/CSF:
ID Card Date: 07/27/2007 (MAILED)

PRO / Trans Cd: 16009910 / 20 Plan Code:
PRO Effect Date: 10/18/2003
Employ Office: CHICAGO OPERATIONS OFFICE

Contract Enrollment Details

Enroll Status	Enroll Code	Trans Code	Event Code	Employment Status	Payroll Office	Effect Date	Proc Date
Current	105	20	09	2	16009910	10/18/2003	[illegible]
Previous	105	30	00	1	89000001	06/13/1993	[illegible]
Previous	104	11	00	1	89000001	05/10/1987	10/10/1992

Member Roster

	Pat Cd	Priv	First Name	MI	Last Name	Addtl Mbr Elig	DOB	Gender	Effect Date	Effect Code	Term Date	T C
▶	A		JULI	A	POLLITT	[redacted]		F	05/10/1987	NEW		
▶	B		MICHAEL	F	POLLITT			M	06/13/1993	ECC	05/10/2015	C

▷ Select Contract Level

quick search | Go To ID | Next Transaction ENROLLMENT INFO | Go

Received 10-17-2007 10:52am From- To-BCBSA Member Service Page 302

Exhibit 1

shawn

Payroll Office Enrollees View

Use the browser Back arrow to select another record to view.

Payroll Office ID	Year	Quarter	Submission
10009910	2007	2	1

10-19-03

Agency	PDI	Carrier	Enrollment Code	SSN
0100	9910	BCBS	104	

Last Name	First Name	Middle Name
POLLITT	JULI	A

Effective Date	Amount
	398.44

Deceased

Annuitant SSN	Pseudo SSN	Other Payroll ID	Other Carrier ID
		102025485	

Submitter Use #1	Submitter Use #2	Submitter Use #3
ACPS20070513200706O9	01146002838400000000	IQNP

Date Processed	Time Processed	Source	Fail Count
06 12 2007	19:59:10		11

Select another discrepancy: 1

Discrepancy	164 - Enrollee On Payroll Office And Carrier Records But Enrollment
Reconciliation Reason	
Reconciliation Action	
Corrective Action	724 - Other - See Comments

Payroll Office Comments (400 character max)	Carrier Comments (400 character max)
	WAITING FOR PAX RESPONSE

	ID	Date	Time
Last Payroll Update:			
Last Carrier Update:	CLC1200	07 18 2007	10:40:23

100

Exhibit 2

U.S. Department of Labor

Office of Workers' Compensation Programs
Office of the District Director
Chicago, IL 60604
(312) 596-7157
Fax (312) 596-7145

[Stamp: Received OCT 3 2007
MEMBER SERVICES]

Total number of pages (including cover sheet): 2

DATE: 10/3/07

FROM: [Handwritten] Juanita Nelson

Please Deliver the Following Document to:

NAME: [Handwritten] Stacy Anthony or Atty Bessie Gant

AGENCY: [Handritten] BC/BS

FAX #: [Handwritten] 202-942-1010 PHONE #: [Handwritten] Case 102025485

Copy of letter sent from claimant's agency concerning transfer out of her family coverage under code 105 effective 08/20/04.

Exhibit 3

[Image omitted] **Department of Energy**
Golden Field Office
1617 Cole Boulevard
Golden, Colorado 80401-3305

September 18, 2007

US Dept of Labor
DFEC Central Mailroom
P.O. Box 8300
London, KY 40742-8300

Dear Mr. Smith:

SUBJECT: Name: Juli A. Pollitt
Case No. 10-2025485
Amended FEHB Coverage

Dear Worker's Comp People:

The Golden Field Office of the U.S. Department of Energy was the servicing personnel office for Ms. Juli Pollitt at the time she was taken off of the Department's rolls and transferred to your rolls, on August 20, 2004. This is to advise you that Ms. Juli Pollitt was enrolled in Blue Cross/Blue Shield with Self and Family Coverage, Enrollment Code 105, while employed by the Department of Energy and this coverage was in effect at the time she was transferred to your rolls. My understanding is that this coverage should have continued.

Attached is a copy of redacted pages from our DOEINFO system showing her coverage at the time she was transferred to your rolls.

Please advise if there is anything else you need to effect this correction. You can contact Kay Gilbert of Gilbert □ Associates at 303-980-5277 (voice) or reach her by e-mail at gilbert286□comcast.net.

Sincerely,

/s/ Thomas A. Kelly

Thomas A. Kelly
Lead Human Resource Specialist
U.S. Department of Energy

Enclosure

cc: Kay Gilbe[rt]
Juli Pollitt

8 1 2 7 8 8 8 9 2 5

16809910
07053

Notice of Change in Health Benefits Enrollment

1. Name (Last, first, middle initial)	2. Date of birth	3. Social security number
POLLITT, JULI A.		
4. Home address (Including ZIP Code)	5. Payroll office number	6. Enrollment code number
912 W. GROVE AVENUE WAUKEGAN, IL 60085	16009910	105
	7. SF 2811 Report number	8. Date this action becomes effective
	753	08/20/2004

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions.
Keep this form for your records.

Part B - Termination

☐ Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date.

Important Notice: You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily extend your group coverage. See Part B - Termination on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.

If termination is due to death of enrollee enter date of death | Date of birth (mo., dy., yr.)

Part C - [illegible]

☒ The new Payroll Office for Retirement Systems shown in Part H below has accepted transfer of this enrollment and will continue it.

Part D - Reinstatement

☐ Your enrollment has been reinstated effective on the date in Part A, item 8, above.

Part E - Change in Name and/or Address

☐ The name under which this enrollment is carried has been changed to:

Name | Date of birth

Address (Including ZIP Code) if different from Part A, item 4, above.

Part F - Conversion to Enrollment Self Only or Family

☐ Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below.

(Note: This item is completed by Retirement Systems only.)

New Enrollment Code Number

Part G - Remarks

Claimant receiving OWCP benefits #102025485.

Part H - Agency Certification

Note: Instructions for Employing Offices are on the back of Copy 5 of this form.

Name and address of agency (Including ZIP Code)	Personnel contact and telephone number
US Department of Labor/OWCP 230 S. Dearborn Street, 8th Floor Chicago, IL 60604	Payroll contact and telephone number B. Miller (312) 596-7157
Signature of authorized agency official B Miller	Date 10-5-07

U.S. Office of Personnel Management — SF 2809 — Revised June 1998

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Exhibit 4

BEST AVAILABLE COPY

United States District Court,
Northern District Of Illinois

Name of Assigned Judge or Magistrate Judge	Robert W. Gettleman	**Sitting Judge if Other than Assigned Judge**	
CASE NUMBER	07 C 5961	**DATE**	11/15/2007
CASE TITLE	Juli Pollitt V Health Care Service Corp.		

DOCKET ENTRY TEXT:

Defendant Health Care Service's motion to dismiss is granted without prejudice. Plaintiff is given leave to file an amended complaint by 11/28/2007. Defendant's responsive pleading is due by 12/19/2007. Status hearing is set for 12/26/2007, at 9:15 a.m.

{Docketing to mail notice}

[Entered: 11/28/2007]

00:08

Courtroom Deputy	GDS

Children's Therapy and Rehab Specialist's
2592 Grand Ave. Suite 209
Lindenhurst, IL. 60046
847 265-1460
FAX 847 265-1650

November 19, 2007

Ms. Juli Pollitt
912 West Grove
Waukegan, IL. 60087

Dear Ms. Pollitt,

Enclosed please find the response from Blue Cross Blue Shield. As you can see, they are requesting the money back even though you have appealed.

Please let me hear from you.

Thank you,

/s/ Paula Cseh

Paula Cseh

[ATTACHMENT]

[Barcode omitted]

[Logos Omitted] BlueCross BlueShield of Illinois

November 9, 2007

CHILDREN'S THERAPY
AND REHAB
1225 S RAND RD
LAKE ZURICH IL 60047-2960

Group Number:
0FEP00
Identification
Number: [ID
Number omitted]
Patient Name:
Michael Pollitt
Claim Number:
432491033510C 00
Service Date:
November 3, 2004
Member's Name:
JULI POLLITT

Dear Doctor or Provider:

Thank you for your recent letter dated 10/29/2007 regarding the claim(s) referenced above. We appreciate the opportunity to assist you.

After reviewing the information you provided regarding a refund request on the referenced claim(s), we determined that the Federal Employee Health Benefits Program should be requesting a refund for the claim(s). Therefore, we must maintain our original request for refund in the amount of $126.00 (Our records indicate that the

patient's membership ended on 10/18/2003). Thank you for your cooperation in this matter.

The Blue Cross and Blue Shield of Illinois Federal Employee Program makes customer service a top priority. We hope this information has been helpful, but if we can be of additional assistance, please contact us toll-free at (800) 972-8382 from 8 a.m. to 4:30 p.m., Monday through Friday.

Sincerely,

Brittney Penson - U268384
Blue Cross and Blue Shield
Customer Service Center

PO BOX 1364 CHICAGO, IL 60690-1364,
www.fepblue.org
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

WALTER I FRIED PHD MD SC 249-4600
3477 GRAND AVENUE
GURNEE, IL 60031-3734

10191-9198

0101

RETURN SERVICE REQUESTED

IF PAYING BY MASTERCARD OR VISA, FILL OUT BELOW

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ VISA

CARD NUMBER | SIGNATURE CODE

SIGNATURE | EXP DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
11/21/07	$116.03	13498

PAGE: 1 of 1

SHOW AMOUNT PAID HERE $

POLLITT, JULI
912 WEST GROVE AVE
WAUKEGAN, IL 60085-1853

WALTER I FRIED PHD MD SC
3477 GRAND AVENUE
GURNEE, IL 60031-3734

10191-9198*TBE11MCJ7000031

☐ Please check box if address or insurance information has changed, and indicate change(s) on reverse side

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT.

DATE	DESCRIPTION OF SERVICE	AMOUNT	INS.BAL	PAT.BAL	LINE ITEM BAL
05/24/06	ENCOUNTER 88610 FOR MICHAEL WITH FRIED , WALTER I.				
05/24/06	92004 - Eye Exam, New Patient	$168.00		$116.03	
11/07/06	Insurance Payment (-/+)	-$153.00			
11/30/06	Patient Payment Cash (-/+)	-$15.00			
10/05/07	Professional Courtesy (- /+)	-$36.97			
10/12/07	Refund Insurance REF (+)	$153.00			
	ENCOUNTER TO	$196.03	$0.00	$116.03	$116.03

CURRENT	30-60 DAYS	60-90 DAYS	90-120 DAYS	OVER 120 DAYS	TOTAL ACCOUNT BALANCE
0.00	116.03	0.00	0.00	0.00	$116.03

DUE FROM PATIENT ▸▸▸▸ $116.03

FOR BILLING INQUIRIES CALL 847-249-4674.

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10191-9198*TBE11MCJ7000031

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRI[C]T OF ILLINOIS

Juli A. Pollitt and	)	[**FILED** NOV 28 2007
Michael A. Nash	)	Michael W. Dobbins
Plaintiffs	)	Clerk, U.S. District
	)	Court]
vs.	)	
	)	No. 07 C 5961
	)	Judge Gettleman
HealthCare Service	)	Magistrate Judge Keys
Corporation	)	
Defendant	)	

AMENDED COMPLAINT

Plaintiffs, Juli A. Pollitt and Michael A. Nash, the parents of minor child, Michael F. Pollitt, complain of Defendant, Health Care Service Corporation, and state as follows:

INTRODUCTION

1. Because Defendant is an insurance company doing business in Illinois and because many of the actions referred to in this complaint took place in Lake County Illinois, jurisdiction and venue for this matter is proper in the Illinois Circuit Court of The Nineteenth Judicial Circuit, and it was originally filed there as No. 07 L 709. The Jurisdiction of this court arises from Defendant's removal of the matter to this court on October 22, 2007, and from the necessity of interpreting certain sections of the Service Benefits Master Contract, a contract between Defendant and the Office of Personnel Management, an agency of the federal government.

2. During the **period in question** in this lawsuit **(from October of 2003 to July of 2007)**, when the eligibility status of Plaintiffs' minor son Michael F. Pollitt was for a time thought to be in doubt, Plaintiff Juli A. Pollitt was on a medial [sic] leave from her former employer, the United States Department Of Energy **("DOE")** and her "employer" was technically the United States Department of Labor **("DOL")**.

3. During the period in question Plaintiff Juli A. Pollitt paid premiums to Defendant under the terms of medical insurance policy #FEP00-[ID Number omitted], covering both herself and her minor child, Michael F. Pollitt, and submitted claims to Defendant for all of the medical expenses of both herself and her minor child, Michael F. Pollitt. During this time, Defendant paid all medical insurance claims for both Juli A. Pollitt and her minor child, Michael F. Pollitt.

4. During the period in question Defendant operated under the terms of the Service Benefits Master Contract **("TheContract")** [sic] that is had concluded with the U.S. Office o[f] Personnel Management. **("OPM")** this contract was written in compliance with the Federal Employees Health Benefits Act **("FEHBA")**.

DUTIES BREACHED

5. **In bad faith, intentionally and with willful and wanton disregard for Plaintiffs' rights and well being, Defendant failed to inform Plaintiffs of a serious potential problem with the insurance coverage for their minor child Michael F. Pollitt, a problem that had existed for nearly four years.**

6. During the period in question, Defendant was the party designated under The Master Contract to provide evidence of enrollee coverage (see Master Contract Section 2.1(2)(c)) It was also the only party with access to all of the records necessary to discover and correct problems with the coverage status of an enrollee.

7. During the period in question, Defendant was aware or should have been aware that other parties would rely on the accuracy of the coverage evidence that it was providing.

8. During the period in question, Defendant had a duty to provide accurate coverage information to all concerned parties. No other party under the terms of The Master Contract assumed that duty.

9. Pursuant to the duty outlined above Defendant had a further duty to make regular and timely reconciliations between its records, upon which benefits were paid, and those of DOL, upon which premiums were paid, if possible with the filing of every benefits claim, in order to verify the coverage status of enrollees. It was this kind of reconciliation performed by Defendant, which had in fact reveled the problem which gave rise to this lawsuit. No other party under the terms of The Master Contract assumed that duty.

10. During the period in question, Defendant was aware or should have been aware that its failure to provide accurate and up to date coverage information could result in serious financial and emotional injury to Plaintiffs, regardless of the eventual outcome of any coverage dispute.

11. At some time prior to July 18, 2007 Defendant informed DOL that it had reconciled its own records

to those of DOL and had discovered a discrepancy between the two. This discrepancy, it claimed, had existed since October 03, 2003, when Plaintiff Juli A. Pollitt moved from DOE to DOL. Michael F. Pollitt was listed as covered in Defendants records and not covered in DOL's. It was then decided, by which party it is not clear, that the coverage status for Michael F. Pollitt would be retroactively changed in Defendant's records.

13. In bad faith, intentionally and with willful and wanton disregard for Plaintiffs' rights and well being, Defendant made no attempt to verify the actual enrollment status of Michael F. Pollitt prior to removing his coverage and initiating collection actions against his medical service providers.

14. Section 2.3(g)(3) of the Master Contract gives carriers, such as Defendant, the right to withhold overpayments from future payments to providers. Parties such as the Plaintiffs in this matter have the right to expect that the enhanced power to safeguard their interests, given to carriers by this provision, would be exercised with responsibility and reasonable restraint. Defendant has an implied duty to exercise this power as such.

15. Upon discovering the discrepancy in question, Defendant was aware or should have been aware that removing Michael F. Pollitt from coverage would require Plaintiffs to find other coverage for him.

16. Upon discovering the discrepancy in question, Defendant was aware or should have been aware that proceeding with collection efforts against the medical service providers for Michael F. Pollitt would create legitimate doubts about the Plaintiffs

in the providers minds and complicate Plaintiffs' future dealings with them.

17. Upon discovering the discrepancy in question, Defendant had a duty to plaintiffs to make reasonable efforts to find the source of it before removing Michael F. Pollitt's coverage and proceeding with collection efforts. This duty coincided with its' duty to provide accurate evidence of enrollee coverage to all concerned parties. It should provided [sic] itself with such accurate evidence before proceeding.

18. Defendant made no attempt at that time to discover the source of the discrepancy or to verify the actual coverage status of Michael F. Pollitt. Instead, on July 31, 2007 Defendant sent notices to10 medical service providers for Michael F. Pollitt, with copies to plaintiffs, informing them that payments it had made to them since October of 2003 had been made in error and would have to be returned.

19. In bad faith, intentionally and with willful and wanton disregard for Plaintiffs' rights and well being, Defendant made no attempt to verify Michael F. Pollitt's actual enrollment status until after Plaintiffs filed their lawsuit.

20. Plaintiffs filed their lawsuit on September 20, 2007.

21. Defendant first received evidence that Michael F. Pollitt was actually covered, in spite of appearances, in a fax from DOL on October 3, 2007. That evidence was available to Defendant but not to Plaintiffs on September 18, 2007 but Defendant did not request it.

22. On or about October 5, 2007, it was decided, by what party is not clear, that coverage for Michael F. Pollitt should be reinstated. Plaintiffs were informed of this on October 17, 2007, but were given no explanation as to why or how this mistake had occurred.

23. In bad faith, intentionally and with willful and wanton disregard for Plaintiffs' rights and well being, Defendant gave Plaintiffs no prior notice of it's plans to remove coverage for Michael F. Pollitt and begin collection actions against his medical service providers, no explanation as to why all of this occurred and no opportunity either to appeal those actions or to offer any compromise resolution of the matter, either before or after those actions were taken.

24. Plaintiffs first became aware of a problem with their son's coverage on July 28, 2007 when an attempt to fill a prescription for him was denied. On July 30, 2007 Plaintiff Juli A. Pollitt called Defendant and was told that his coverage had been terminated but was not told why that had occurred or what steps Defendant intended to take as a result.

25. On July 31 made its requests to the providers, with copies to Plaintiffs. Although in the notices the providers were informed of a right of appeal no such announcement was ever made to Plaintiffs by Defendant.

26. On August 1, 2007 Plaintiff Juli A. Pollitt received an ID card from Defendant, attached to a letter indicating that this was her "new" card and that it reflected changes that she had "recently" made in her enrollment. The letter was dated only by reference to the date on the card, October 3, 2003.

This was the only formal notice about this matter that was ever addressed to Plaintiffs by Defendant or any one else until August 17, 2007, nearly a month after they filed their lawsuit.

27. In bad faith, intentionally and with willful and wanton disregard for Plaintiffs' rights and well being, Defendant, upon discovering the discrepancy in question, opted to retroactively deny coverage for Michael F. Pollitt, in stead of asking for back premiums, because of his extensive claims history.

28. Once again, Defendant's duty to plaintiffs in this instance arises, at least in part, from it's implied obligation to make appropriate use of the set off powers given to it in section 2.3(g)(3) of the Master Contract.

29. In spite of Defendant's claims to the contrary, Plaintiffs have seen no evidence that DOL provided any direction to Defendant during any phase of this matter. It is Defendant that seems clearly to have been in charge at every juncture.

30. Plaintiffs were informed in August of 2007 by the Office of Worker's Compensation that payment of back premiums was the normal method of resolving matters such as this. Plaintiffs then learned that Defendant had decided to retractively deny coverage instead. Defendant has now reinstated Michael F. Pollitt and is asking for back premiums. Plaintiffs have received no indication from any party as to why this was not the method of resolution employed initially. Plaintiffs can only assume that Michael's claims history was the reason.

31. In bad faith, intentionally and with willful and wanton disregard for Plaintiffs' rights and well being, Defendant has not, as of the date of this filing,

informed the medical service providers for Michael F. Pollitt that it no longer intends to collect from them.

32. As of October 3, 2007 Defendant knew or should have known that Plaintiffs would suffer further injury from any delay in notifying their son's providers of his reinstatement.

33. As of October 3, 2007 Defendant had a duty to notify the medical service providers for Michael F. Pollitt as quickly as possible of his change in coverage. Having created concerns about Plaintiffs' responsibility and reliability in providers' minds it had the obligation to address those concerns promptly.

34. As of November 28, 2007, Defendant has made no such notification.

35. In bad faith, intentionally and with willful and wanton disregard for Plaintiffs' rights and well being, Defendant's actions outlined above were not isolated incidents. They were the result of deliberate policy decisions made by Defendant management.

INJURIES SUFFERED

36. As a result of the intentional, willful and wanton acts of Defendant, Plaintiffs, during the period that their son's eligibility was in doubt, were required to provide individual medical insurance for him at a much higher price than they might otherwise have paid in a group policy. The premiums for this policy will also be in addition to the back premiums that they will now have to pay for Juli A. Pollitt's group policy.

37. As a result of the intentional, willful and wanton acts of Defendant, Plaintiffs will now have to pay four years worth of back premiums for their son's insurance. Plaintiffs did not budget for those amounts during the period in question and will now be required to borrow money at interest to pay them all at once.

38. As a result of the intentional, willful and wanton acts of Defendant, Plaintiffs were faced for weeks with the prospect of repaying over four years of medical bills for their son. They experienced severe mental suffering and emotional distress, which, in the case of Plaintiff Juli A. Pollitt, required professional treatment.

39. As a result of the intentional, willful and wanton acts of Defendant, Plaintiffs were publicly humiliated in front of their son's medical service providers and forced to address embarrassing inquiries from them, a situation which continued to the current day.

40. As a result of the intentional, willful and wanton acts of Defendant, a least one medical provider for Michael A. Pollitt has expressed reluctance to treat him in the future and has requested to now be paid directly in cash. Plaintiffs have reason to believe that others among their son's providers share this sentiment.

41. These injuries to Plaintiffs were readily foreseeable to Defendant from its actions.

PRAYER FOR RELIEF

Wherefore, Plaintiffs pray that this Court grant the following relief:

A. Grant plaintiffs' demand for a jury trial of this cause of action.

B. Enter judgment for Plaintiffs and against Defendant, directing Defendant to inform all medical service providers for Plaintiffs' minor child, Michael F. Pollitt, that they will no longer be required to return the money that Defendant had requested of them.

C. Award to Plaintiffs the sum of $300,000, in compensatory damages for the expenses they have incurred and will incur as a result of the intentional, willful and wanton acts of Defendant, and for the mental suffering, emotional distress and public humiliation they have endured and will endure as a result of these acts.

D. Award the plaintiffs the sum of $1,500,000, in punitive damages for the bad faith displayed by Defendant in committing its intentional, willful and wanton acts.

E. Award to Plaintiffs the costs of this suit and such other damages, as the court shall deem appropriate.

F. Award to Plaintiffs an amount equal to 10% per year of all damages awarded in this suit, compounded daily from the date this complaint was filed.

/s/

Juli A. Pollitt
912 W. Grove Avenue
Waukegan, Illinois 60085
847-672-6450

/s/

Michael A. Nash
12538 W. Bairstow Avenue
Beach Park, IL 60087
847-263-9504

[Certificate of Service omitted]

Midwest Children's Heart Specialists, S. C.
1575 North Barrington Road, Suite 430
Hoffman Estates, Illinois 60194-1065
(847) 884-1353

12/11/07

JULI POLLITT
912 WEST GROVE AVENUE
WAUKEGAN, IL 60085

Account: # 18147

Dear Ms. POLLITT:

YOUR ACCOUNT IS PAST DUE! BALANCE DUE: $ 195.00

We have been pleased to provide care for you. No interest has been charged on your account, but you have failed to respond to our previous notifications. Your failure to respond makes it necessary for us to take further action.

Please respond with payment immediately, or call me at (847) 884-1353 to discuss this account.

You may pay by Credit Card.

Visa ___ Mastercard ___ Discover ___

Account #_____

3 digit Security Code _____ Exp Date _____

Signature _____

Sincerely,

BILLING DEPARTMENT
Office Coordinator

[Stamp: If you are unable to pay in full PLEASE SEND A PARTIAL PAYMENT]

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS

Juli A. Pollitt and	)	[**FILED** DEC 26 2007
Michael A. Nash	)	Judge Robert W.
Plaintiffs	)	Gettleman
	)	United States
	)	District Court]
vs.	)	
	)	[Other Court Stamps
	)	Omitted]
	)	
HealthCare Service)		**No. 07 C 5961**
Corporation	)	**Judge Gettleman**
Defendant	)	**Magistrate Judge Keys**

SECOND AMENDED COMPLAINT

Plaintiffs, Juli A. Pollitt and Michael A. Nash, the parents of minor child, Michael F. Pollitt, complain of Defendant, Health Care Service Corporation, and state as follows:

1. Because defendant is an insurance company doing business in Illinois and because many of the actions referred to in this complaint took place in Lake County Illinois, jurisdiction and venue for this matter is proper in the Illinois Circuit Court of The Nineteenth Judicial District, and it was originally filed there as No. 07 L 709. The Jurisdiction of this court arises from Defendant's removal of the matter to this court on October 22, 2007, and from the possible necessity of interpreting certain sections of the Federal Employees Health Benefits Act and the Service Benefits Master Contract, a contract

between Defendant and the Office of Personnel Management, an agency of the federal government.

2. During the **period in question** in this lawsuit **(from October of 2003 to July of 2007)**, when the eligibility status of Plaintiffs' minor son, Michael F. Pollitt was for a time thought to be in doubt, Plaintiff Juli A. Pollitt was on a medical leave from her former employer, the United States Department of Energy **("DOE")** and her "employer" was technically the United States Department of Labor **("DOL")**.

3. During the period in question Plaintiff Juli A. Pollitt paid premiums to Defendant under the terms of medical insurance policy #FEP00-[ID Number omitted], covering both herself and her minor child, Michael F. Pollitt, and submitted claims to Defendant for all of the medical expenses of both herself and her minor child, Michael F. Pollitt. During this time, Defendant paid all medical insurance claims for both Juli A. Pollitt and her minor child, Michael F. Pollitt.

4. During the period in question Defendant operated under the terms of the Service Benefits Master Contract **("The Contract")** that it had concluded with the U.S. Office or Personnel Management. **("OPM")** this contract was written in compliance with the Federal Employees Health Benefits Act **("FEHBA")**.

DUTIES BREACHED

5. **In bad faith, intentionally and with willful and wanton disregard for Plaintiffs' rights and well being, Defendant failed to take reasonable and appropriate steps to discover and inform Plaintiffs of a serious potential problem with the insurance**

coverage for their minor child Michael F. Pollitt, a problem that had existed for nearly four years.

6. During the period in question, Defendant was the party designated under The Master Contract to provide evidence of enrollee coverage (see Master Contract Section 2.1(2)(c)) It was also the only party with access to all of the records necessary to discover and correct problems with the coverage status of an enrollee.

7. During the period in question, Defendant was aware or should have been aware that other parties would rely on the accuracy of the coverage evidence that it was providing.

8. During the period in question, Defendant had a duty to provide accurate coverage information to all concerned parties. No other party under the terms of The Master Contract assumed that duty.

9. Pursuant to the duty outlined above Defendant had a further duty to make regular and timely reconciliations between its records, upon which benefits were paid, and those of DOL, upon which premiums were paid, if possible with the filing of every benefits claim, in order to verify the coverage status of enrollees. It was this kind of reconciliation performed by Defendant, which had in fact reveled the problem which gave rise to this lawsuit. No other party under the terms of the Master Contract assumed that duty.

10. During the period in question, Defendant was aware or should have been aware that its failure to provide accurate and up to date coverage information could result in serious financial and emotional injury to Plaintiffs, regardless of the eventual outcome of any coverage dispute.

11. At some point prior to July 18, 2007 Defendant informed DOL that it had reconciled its own records to those of DOL and had discovered a discrepancy between the two. This discrepancy, it claimed, had existed since October 03, 2003, when Plaintiff Juli A. Pollitt moved from DOE to DOL. Michael F. Pollitt was listed as covered in Defendants records and not covered in DOL's. It was then decided, by which party it is not clear, that the coverage status for Michael F. Pollitt would be retroactively changed in Defendant's records.

13. In bad faith, intentionally and with willful and wanton disregard for Plaintiffs' rights and well being, Defendant failed to take reasonable and appropriate steps to verify the actual enrollment status of Michael F. Pollitt prior to removing his coverage and initiating collection actions against his medical service providers.

14. Section 2.3(g)(3) of the Master Contract gives carriers, such as Defendant, the right to withhold overpayments from future payments to providers. Parties such as the Plaintiffs in this matter have the right to expect that the enhanced power to safeguard their interests, given to carriers by this provision, would be exercised with responsibility and reasonable restraint. Defendant has an implied duty to exercise this power as such.

15. Upon discovering the discrepancy in question, Defendant was aware or should have been aware that retroactively removing Michael F. Pollitt from coverage would require Plaintiffs to find other coverage for him and could result in serious financial and emotional injury to them.

16. Upon discovering the discrepancy in question, Defendant was aware or should have been aware that proceeding with collection efforts against the medical service providers for Michael F. Pollitt would create legitimate doubts about Plaintiffs in the providers minds and complicate Plaintiffs' future dealings with them.

17. Upon discovering the discrepancy in question, Defendant had a duty to plaintiffs to make reasonable efforts to find the source of it before removing Michael F. Pollitt's coverage and proceeding with collection efforts. This duty coincided with its' duty to provide accurate evidence of enrollee coverage to all concerned parties. It should have provided itself with such accurate evidence before proceeding.

18. Defendant failed to take reasonable and appropriate steps at that time to discover the source of the discrepancy or to verify the actual coverage status of Michael F. Pollitt. Instead, on July 31, 2007 Defendant sent notices to10 medical service providers for Michael F. Pollitt, with copies to plaintiffs, informing them that payments it had made to them since October of 2003 had been made in error and would have to be returned.

19. In bad faith, intentionally and with willful and wanton disregard for Plaintiffs' rights and well being, Defendant failed to take reasonable and appropriate steps to verify Michael F. Pollitt's actual enrollment status until after Plaintiffs filed their lawsuit.

20. Plaintiffs filed their lawsuit on September 20, 2007.

21. Defendant first received evidence that Michael F. Pollitt was actually covered, in spite of appearances, in a fax from DOL on October 3, 2007. That evidence was available to Defendant but not to Plaintiffs on September 18, 2007 but Defendant did not request it.

22. On or about October 5, 2007, it was decided, by what party it is not clear, that coverage for Michael F. Pollitt should be reinstated. Plaintiffs were informed of this on October 17, 2007, but were given no explanation as to why or how this mistake had occurred.

23. In bad faith, intentionally and with willful and wanton disregard for Plaintiffs' rights and well being, Defendant gave Plaintiffs no prior notice of it's plans to remove coverage for Michael F. Pollitt and begin collection actions against his medical service providers, no explanation as to why all of this occurred and no opportunity either to appeal those actions or to offer any compromise resolution of the matter, either before or after those actions were taken.

24. Plaintiffs first became aware of a problem with their son's coverage on July 28, 2007 when an attempt to fill a prescription for him was denied. On July 30, 2007 Plaintiff Juli A. Pollitt called Defendant and was told that his coverage had been terminated but was not told why that had occurred or what steps Defendant intended to take as a result.

25. On July 31 made its requests to the providers, with copies to Plaintiffs. Although in the notices the providers were informed of a right to appeal no such announcement was ever made to Plaintiffs by Defendant.

26. On August 1, 2007 Plaintiff Juli A. Pollitt received an ID card from Defendant, attached to a letter indicating that this was her "new" card and that it reflected changes that she had "recently" made in her enrollment. The letter was dated only by reference to the date on the card, October 3, 2003. This was the only formal notice about this matter that was ever addressed to Plaintiffs by Defendant or any one else until August 17, 2007, nearly a month after they filed their lawsuit.

27. In bad faith, intentionally and with willful and wanton disregard for Plaintiffs' rights and well being, Defendant, upon discovering the discrepancy in question, opted to retroactively deny coverage for Michael F. Pollitt, instead of asking for back premiums, because of his extensive claims history.

28. Once again, Defendant's duty to plaintiffs in this instance arises, at least in part, from it's implied obligation to make appropriate use of the set off powers given to it in section 2.3(g)(3) of the Master Contract.

29. In spite of Defendant's claims to the contrary, Plaintiffs have seen no evidence that DOL provided any direction to Defendant during any phase of this matter. It is Defendant that seems clearly to have been in charge at every juncture.

30. Plaintiffs were informed in August of 2007 by the Office of Worker's Compensation that payment of back premiums was the normal method of resolving matters such as this. Plaintiffs then learned that Defendant had decided to retroactively deny coverage instead. Defendant has now reinstated Michael F. Pollitt and is asking for back premiums. Plaintiffs have received no indication from any party

as to why this was not the method of resolution employed initially. Plaintiffs can only assume that Michael's claims history was the reason.

31. Having, by its own deliberate actions and/or omissions, created uncertainty over the coverage status of Michael F. Pollitt, Defendant had a duty to Plaintiffs to resolve that uncertainty in the manner with the least foreseeable damage to them.

32. In bad faith, intentionally and with willful and wanton disregard for Plaintiffs' rights and well being, Defendant has not, as of the date of this filing, informed all of the medical service providers for Michael F. Pollitt that it no longer intends to collect from them.

33. As of October 3, 2007 Defendant knew or should have known that Plaintiffs would suffer further injury from any delay in notifying their son's providers of his reinstatement.

34. As of October 3, 2007 Defendant had a duty to notify the medical service providers for Michael F. Pollitt as quickly as possible of his change in coverage. Having created concerns about Plaintiffs' responsibility and reliability in providers' minds it had the obligation to address those concerns promptly.

35. As of November 28, 2007, Defendant has made no such notification.

36. In bad faith, intentionally and with willful and wanton disregard for the Plaintiffs' rights and well being, Defendant's actions outlined above were not isolated incidents. They were the result of deliberate policy decisions made by Defendant management.

INJURIES INCURRED

37. As a result of the intentional, willful and wanton acts of Defendant, Plaintiffs, during the period that their son's eligibility was in doubt, were required to provide individual medical insurance for him at a much higher price than they might otherwise have paid in a group policy. The premiums for this policy will also be in addition to the back premiums that they will now have to pay for Juli A. Pollitt's group policy.

38. As a result of the intentional, willful and wanton acts of Defendant, Plaintiffs will now have to pay four years worth of back premiums for their son's insurance. Plaintiffs did not budget for those amounts during the period in question and will now be required to borrow money at interest to pay them all at once.

39. As a result of the intentional, willful and wanton acts of Defendant, Plaintiffs were faced for weeks with the prospect of repaying nearly four years of medical bills for their son. They experienced severe mental suffering and emotional distress, which, in the case of Plaintiff Juli A. Pollitt, required professional treatment.

40. As a result of the intentional, willful and wanton acts of Defendant, Plaintiffs were publicly humiliated in front of their son's medical service providers and forced to address embarrassing inquiries from them, a situation which continued to the current day.

41. As a result of the intentional, willful and wanton acts of Defendant, a least one medical provider for Michael A. Pollitt has expressed reluctance to treat him in the future and has

requested to now be paid directly in cash. Plaintiffs have reason to believe that others among their son's providers share this sentiment.

42. These injuries to Plaintiffs were readily foreseeable to Defendant from its actions.

Wherefore, Plaintiffs pray that this Court grant the following relief:

A. Grant plaintiffs' demand for a jury for the trial of this cause of action.

B. Enter judgment for Plaintiffs and against Defendant, directing Defendant to inform all medical service providers for Plaintiffs' minor child, Michael F. Pollitt, that they will no longer be required to return the money that Defendant had requested of them.

C. Award to Plaintiffs the sum of $300,000, in compensatory damages for the expenses they have incurred and will incur as a result of the intentional, willful and wanton acts of Defendant, and for the mental suffering, emotional distress and public humiliation they have endured and will endure as a result of these acts.

D. Award to plaintiffs the sum of $ 1,500,000, in punitive damages for the bad faith displayed by Defendant in committing its intentional, willful and wanton acts.

E. Award to Plaintiffs the costs of this suit and such other damages, as the court shall deem appropriate.

F. Award to Plaintiffs an amount equal to 10% per year of all damages awarded in this suit, compounded daily from the date this complaint was filed.

/s/

Juli A. Pollitt
912 W. Grove Avenue
Waukegan, Illinois 60085
847-672-6450

/s/

Michael A. Nash
12538 W. Bairstow Avenue
Beach Park, IL 60087
847-263-9504

[Certificate of Service omitted]

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS

Juli A. Pollitt and	)	[FILED APR 9 2008
Michael A. Nash	)	[Handwritten: 4-9-2008]
Plaintiffs	)	MICHAEL W. DOBBINS
	)	CLERK, U.S. DISTRICT
	)	COURT]
	)	
vs.	)	**No. 07 C 5961**
	)	**Honorable Blanche M.**
	)	**Manning**
	)	
	)	
HealthCare Service	)	
Corporation	)	
Defendant	)	

PLAINTIFFS' MOTION FOR DISCOVERY

Plaintiffs respectfully request that the court order Defendant to honor Plaintiff's request for the following data and documents, first submitted to the Circuit Court of Lake County, Illinois on September 10, 2007, as part of a larger request.

1. All correspondence, either internal or external, including Emails, for the period of time Since June 13, 1993, located anywhere in Defendant's possession, concerning Juli A. Pollitt or Michael F. Pollitt or policy #FEP00-[ID Number omitted].

2. The electronic metadata accompanying whichever of the above documents were generated on Defendant's computer systems, showing their authors and dates of creation.

3. All database records Concerning Juli A. Pollitt, Michael F. Pollitt or Policy #FEP00-[ID Number omitted], as they existed both before and after any changes made to them since June 13, 1993, along with the dates and authors of those changes.

WHEREFORE, Plaintiffs Michael A. Nash and Juli A. Pollitt respectfully move that Defendant be ordered to honor the above request.

Respectfully submitted

/s/

Juli A. Pollitt
912 W. Grove Avenue
Waukegan, Illinois 60085
847-672-6450

/s/

Michael A. Nash
12538 W. Bairstow Avenue
Beach Park, IL 60087
847-263-9504

United States District Court,
Northern District Of Illinois

Name of Assigned Judge or Magistrate Judge	Robert W. Gettleman	**Sitting Judge if Other than Assigned Judge**	
CASE NUMBER	07 C 5961	**DATE**	9/5/2008
CASE TITLE	Juli Pollitt vs Michael A. Nash		

DOCKET ENTRY TEXT:

Defendant's motion [18] to dismiss is granted and this matter is dismissed with prejudice.

{For further detail see separate order}

{Docketing to mail notice}

[Entered: 09/09/2008]

00:00

Courtroom Deputy	GDS

[Image omitted]

Complete
Orthopaedic
Care

100 Village Green Drive, Suite 120 · Lincolnshire, IL 60069
T: (847) 634-1766 · F: (847) 634-2894

10/22/08

POLLITT, MICHAEL
912 W Grove Street
Waukegan, IL 60085

RE: POLLITT, MICHAEL
ACCOUNT # : 57754
BALANCE DUE: [Handwritten] $ 276.00

PLEASE BE ADVISED . . . .

It is no longer practical to carry the above balance on our records and we are, therefore, preparing your account of 122.00 for referral to a COLLECTION AGENCY for further handling.

Accordingly, unless payment is received within 15 days your account will be referred to our Collection Agency.

PAYMENT MADE BY RETURN MAIL WILL ELIMINATE THE NECESSITY FOR THIS ACTION!!!

Handwritten note in original: □ Blue Cross took monies back so we have no payment.

After the above date, all correspondence and communication must be handled with our collection agency.

Sincerely,

/s/ Kelly 847-808-3141 [Handwritten]

BILLING DEPARTMENT
(847) 634-2266

Charles E. Frank, M.D. • Joseph A. Meis, M.D. • Mark A. Neault, M.D. • Marvin L. Primack, M.D. • Matthew L. Primack, P.T. • Rosie Dussault, R.N.

Screen Print on Tuesday, October 14, 2008

atient #: 57754.0 Voucher #: 158507 Clm #: 0609012H
ame: POLLITT, MICHAEL Dr /Dept #: 5 / 1 Location :
ef.Dr.: 389 [SANA ATTAR MD] Ail/Assign: Yes / Yes Post Loc# : 0
Comment: BACK RG

ates	Proc/Modify	Diag	Units	Stat	Approved	Charges	Balance
9/13/06	99243	847.2	1	4	0.00	276.00	261.00

Original Bill to Ins 2 : 09/26/06
osted : 09/25/06 Pat Resp: 08/06/07 Ins 2 : 09/26/06 Ins 0 :
eceipts: 15.00 [Patient: 15.00 Medicare: 0.00 Insurance: 0.00]

[Credit Detail]

Type	Source	Method	Dt Posted	Pmt Amt	Voucher	Amount
PMT	INS #2		08/06/07	-139.00	REFUNDBC	-139.00
	[KB REFUND BC PTS POLICY TERM]					
A52	BC/BS PPO		08/06/07	-122.00		-122.00
	[KB REV BC ADJ PTS INS POLICY TERM]					
A00			08/06/07	0.00		0.00
	[KB BILL IT PTS RESP PER BC INS TERM]					

(A)ilment Info, (H)ardcopy, or (N)ext/(P)rev Detail Page : .

UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

Everett McKinley Dirksen United States Courthouse Room 2722 - 219 S. Dearborn Street Chicago, Illinois 60604

Office of the Clerk
Phone (312) 435-5850
www.ca7.uscourts.gov

FINAL JUDGMENT

March 10, 2009

BEFORE: FRANK H. EASTERBROOK, Chief Judge
ILANA DIAMOND ROVNER, Circuit Judge
TERENCE T. EVANS, Circuit Judge

No.: 08-3509	JULI A. POLLITT, et al., Plaintiffs - Appellants v. HEALTH CARE SERVICE CORPORATION, Defendant - Appellee

Originating Case Information:
District Court No: 1:07-cv-05961 Northern District of Illinois, Eastern Division District Judge Robert Gettleman

The judgment of the District Court is VACATED and REMANDED for further proceedings, in accordance with the decision of this court entered on this date. Appellants recover their costs.

PETITIONER'S BRIEF

Supreme Court, U.S.
FILED
DEC 11 2009
OFFICE OF THE CLERK

(5)

No. 09-38

IN THE

Supreme Court of the United States

HEALTH CARE SERVICE CORPORATION,

Petitioner,

v.

JULI A. POLLITT and MICHAEL A. NASH,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF FOR PETITIONER

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BOTH SAIENQ

593 A

QUESTIONS PRESENTED

1. Whether the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-14, completely preempts -- and therefore makes removable to federal court -- a state court suit challenging enrollment and health benefits determinations that are subject to the exclusively federal remedial scheme established in FEHBA.

2. Whether the federal officer removal statute, 28 U.S.C. § 1442(a)(1), which authorizes federal removal jurisdiction over state court suits brought against persons "acting under" a federal officer when sued for actions "under color of [federal] . . . office," encompasses a suit against a government contractor administering a FEHBA plan, where the contractor is sued for actions taken pursuant to the government contract.

PARTIES TO THE PROCEEDING

All of the parties to the proceeding are identified in the case caption.

STATEMENT PURSUANT TO RULE 29.6

Health Care Service Corporation, an Illinois Mutual Legal Reserve Company, is not a publicly traded company, and no publicly held company owns ten percent or more of its stock. It has no parent corporation.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-4a) is reported at 558 F.3d 615. The opinion of the district court (Pet. App. 5a-8a) is not reported.

JURISDICTION

The judgment of the court of appeals was entered on March 10, 2009. Petitioner timely filed a petition for rehearing and for rehearing *en banc*. The court of appeals denied the petition on April 8, 2009. The petition for a writ of certiorari was filed on July 7, 2009. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Relevant statutes and regulations are reprinted in Appendix E to the petition for a writ of certiorari, at Pet. App. 11a-19a.

STATEMENT

This case presents questions concerning the federal courts' removal jurisdiction. The critical event leading to the underlying lawsuit was the federal government's mistaken direction to terminate retroactively the enrollment of Respondents' minor child in one of the government's health benefits plans for federal employees. Petitioner Health Care Service Corporation ("HCSC"), an administrator of the relevant plan, followed the government's instruction and began the process of recouping benefits previously paid on the minor's behalf, as required by the government contract detailing HCSC's obligations. A short time later, the

government corrected its error, the minor was re-enrolled, and HCSC rescinded the recoupment requests.

Respondents in the meantime had commenced an action to compel the minor's re-enrollment, to stop the retroactive denials of benefits, and for $12 million in damages for alleged emotional distress. Although the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-14, and its implementing regulations, in conjunction with the Administrative Procedure Act ("APA"), 5 U.S.C. §§ 701-06, set forth federal remedies for Respondents' grievances to be pursued solely against the government in federal court, Respondents sued *HCSC* in *state court* under *state law*. HCSC removed the case to federal court, and the district court thereafter found jurisdiction and dismissed the case as preempted by FEHBA. The court of appeals, however, erroneously reinstated the lawsuit, rejecting two different meritorious grounds for removal. First, the available federal remedies "completely preempt" state law and therefore make Respondents' case removable to federal court. Alternatively, the federal officer removal statute, 28 U.S.C. § 1442(a)(1), authorizes removal because HCSC was acting in furtherance of its duties under a federal program supervised by a federal agency.

A. Statutory, Regulatory, and Contractual Regime

1. *The Service Benefit Plan*. As described in *Empire HealthChoice Assurance, Inc.* v. *McVeigh*, 547 U.S. 677, 682 (2006), the Court's only prior decision involving FEHBA, Congress in FEHBA "establishe[d] a comprehensive program of health insurance for federal employees." The statute "authorizes the Office of

Personnel Management (OPM) to contract with private carriers to offer federal employees an array of health-care plans." *Id.*; *see also* 5 U.S.C. § 8902(a). "Largest of the plans for which OPM has contracted annually, since 1960, is the Blue Cross Blue Shield Service Benefit Plan (Plan), administered by local Blue Cross Blue Shield companies." *Empire*, 547 U.S. at 682. In recent years, the Blue Cross and Blue Shield Association ("BCBSA") -- the Plan's designated "carrier" -- has negotiated and signed the contract, known as "CS 1039," on behalf of local Blue Cross and Blue Shield companies, who then administer the Plan in their respective localities. *See id.* at 683-84; *see also* J.A. 12, 57-58. HCSC is the local company administering the Plan in Illinois.

2. *Enrollment Procedures*. FEHBA specifically addresses enrollment in FEHBA plans, including an express delegation to OPM to issue governing regulations. *See* 5 U.S.C. §§ 8905, 8913(b)-(c). Under OPM's regulations, federal employees enroll in the Plan through the particular federal agency for which they work. *See id.* § 8905(a); 5 C.F.R. §§ 890.101(a), 890.102, 890.104; *see also* 5 C.F.R. Pt. 890, subpts. C, D, and K. CS 1039 emphasizes that the government, not the carrier, is responsible for enrollment. *See* J.A. 34 (comprehensive listing of coverage issues that "shall all be determined in accordance with regulations or directions of OPM given pursuant to [FEHBA].").

Once enrolled in the Plan, enrollees are responsible for about 25% of the premium, with the government paying the remainder. *See* 5 U.S.C. § 8906(b)(1), (b)(2), (f). The enrollees' and the government's contributions are placed in a fund in the U.S. Treasury, from

which the Blue Cross and Blue Shield entities draw directly to pay benefits. *See id.* § 8909(a); 48 C.F.R. § 1632.170(b); *see generally Empire*, 547 U.S. at 684.

3. *Enrollment Disputes*. With respect to enrollment disputes, OPM's regulations provide for administrative review within the pertinent federal employing federal agency. *See* 5 C.F.R. § 890.104. The employing agency first makes an "initial decision" on any enrollment issues, and then an affected individual may seek reconsideration, which yields a "final decision . . . in writing." *Id.* OPM's regulations also address judicial review thereafter, specifying that "[a] suit to compel enrollment . . . must be brought against the employing office that made the enrollment decision." *Id.* § 890.107(a).

4. *Benefits Provisions*. OPM's "contracts with carriers, FEHBA instructs, 'shall contain a detailed statement of benefits offered.'" *Empire*, 547 U.S. at 684 (quoting 5 U.S.C. § 8902(d)); *see also* 5 U.S.C. § 8907(b). CS 1039, accordingly, instructs the carrier to provide benefits in accordance with an "appended brochure" that outlines at length the panoply of medical costs the Plan will reimburse. *Empire*, 547 U.S. at 684.

CS 1039 also details the actions the carriers are required to take to recapture benefits erroneously paid. The contract provides: "If the Carrier or OPM determines that a Member's claim has been paid in error for any reason (except fraud and abuse), the Carrier shall make prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider." J.A. 40.

5. *Benefits Disputes*. FEHBA and OPM's regulations likewise demarcate the remedy for benefits disputes. Under FEHBA, OPM contracts must require the carrier to cover a health service if OPM "finds that the employee . . . is entitled thereto under the terms of the contract." 5 U.S.C. § 8902(j). OPM has implemented this provision by establishing a mandatory administrative remedy at OPM for those who believe that a FEHBA plan has wrongfully denied benefits. *See* 5 C.F.R. §§ 890.105, 890.107(d)(1).

OPM's regulations also provide that any court litigation over benefits may be brought only as an action *against OPM* for judicial review of its administrative decision. *See id.* § 890.107(c) (emphasis added). The regulations state that litigation "must be brought against OPM and not against the carrier or carrier's subcontractors." *Id.* In addition, no suit whatsoever shall be commenced "prior to exhaustion of the [OPM] administrative remed[y]." *Id.* § 890.107(d)(1). "The recovery in such a suit shall be limited to a court order directing OPM to require the carrier to pay the amount of benefits in dispute." *Id.* § 890.107(c). A jurisdictional provision in FEHBA ensures that these suits, and the suits to compel enrollment described earlier, may proceed in federal court: "The district courts of the United States have original jurisdiction, concurrent with the United States Court of [Federal] Claims, of a civil action or claim against the United States founded on this chapter." 5 U.S.C. § 8912.

6. *FEHBA's Preemption Provision*. FEHBA contains an express preemption provision. As amended in 1998, the provision states:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1). In enacting the current preemption language, which "broaden[ed]" an earlier version (H.R. Rep. No. 105-374, at 9 (1997)), Congress sought "[t]o assure uniform coverage and benefits under plans OPM negotiates for federal employees," *Empire*, 547 U.S. at 686, and to "confirm" that FEHBA contract terms on benefits and coverage "completely displace" state law " R. Rep. No. 105-374, at 16.

B. The Lawsuit

Respondent Juli Pollitt is an enrollee in the Service Benefit Plan. *See* J.A. 96-97, 124. Through her enrollment, HCSC also had, from 1993 to July 2007, provided benefits to her minor son, as her dependent. *See id.* at 96-99. In October 2003, Ms. Pollitt went on medical leave from her employer, the Department of Energy ("DOE"), at which point her employer technically became the Department of Labor ("DOL"). *Id.* at 124.

In June 2007, in response to an "enrollment reconciliation report" conducted by BCBSA comparing its enrollment data with data provided by employing agencies, the DOL sent BCBSA a form instructing that, since "10-19-03," Ms. Pollitt's coverage had actually been under "Enroll Code 104" or "Self" coverage, not "Enroll Code 105" or "Self and Family" coverage.

J.A. 97, 100; *see generally* 5 C.F.R. § 890.110(b) (outlining carrier's obligation routinely to conduct enrollment data reviews and seek employing agency's direction on discrepancies). Consistent with the DOL's instructions from the form, Ms. Pollitt thereafter received a new Plan identification card reflecting the retroactive termination of the minor's enrollment, *see* J.A. 129; and HCSC, pursuant to its government contract obligations (*see supra* p. 4), began the process of requesting from providers who had rendered services to the minor after October 2003 refunds of any Plan payments. *See* J.A. 128-29.

Ms. Pollitt, joined by the minor's father, Respondent Michael Nash, who is not an enrollee in the Plan, then commenced the underlying action in state court. The original complaint sought re-enrollment of the minor in the Plan, challenged the retroactive denial of benefits earlier paid on his behalf, asserted that HCSC acted in bad faith in administering his coverage, and demanded more than $12 million in damages. *Id.* at 81-82.

A few weeks later, HCSC received a copy of a letter from DOE to DOL directing that the minor should be reinstated because the earlier instruction had been a mistake; two days later, the minor was reinstated. *Id.* at 97, 102-03. HCSC informed Ms. Pollitt that her son had been reinstated in the Plan and that it would rescind any refund requests. *See id.* at 84.

Based on the allegations in the original complaint, HCSC timely removed the case to the U.S. District Court for the Northern District of Illinois.

C. Proceedings in Federal Court

Once pending in federal court, HCSC moved to dismiss some of the claims in the original complaint as moot, because by then the minor had been re-enrolled and HCSC had reversed the retroactive denials of benefits. HCSC also moved to dismiss all claims on grounds of FEHBA preemption and to dismiss Mr. Nash's claims for lack of standing.

The district court granted the motion to dismiss the original complaint, but also granted leave to amend the complaint. Pet. App. 10a. In the amended complaint, and then in a second amended complaint that became the operative pleading, Respondents continued to challenge the alleged retroactive denial of benefits for their son, alleging that HCSC had not rescinded earlier refund requests. *See* J.A. 116-17, 119, 129-30, 132. Respondents also continued to assert bad faith, seeking $1.8 million in compensatory and punitive damages. *See id.* at 132. Respondents at no time moved to remand the case to state court.

The district court then dismissed the second amended complaint, finding that "this case was properly removed from state court, that plaintiff Nash has no standing in this action, and that plaintiff Pollitt's claims are preempted and precluded by federal law." Pet. App. 8a.

The district court explained that grievances concerning enrollment in and benefits under the Plan are subject exclusively to federal remedies. The court noted that "Pollitt's remedy is governed by federal regulation[s] that require[] suits to compel enrollment to be brought 'against the [federal agency] employing office that made the enrollment decisions.'" *Id.* at 7a

(quoting 5 C.F.R. § 890.107(a)). The court also emphasized that "all litigation involving benefits 'must be brought against OPM and not against the carrier or carrier's subcontractors.'" Pet. App. 7a (quoting 5 C.F.R. § 890.107(d)(1)). Pointing to OPM's establishment of "an administrative review mechanism to prosecute claims concerning FEHBA benefits and administration of FEHBA plans" (*id.* at 8a), the court ruled that "plaintiffs were required to prosecute their grievances through the administrative process." *Id.*

Summing up its analysis, the district court said it "share[d] plaintiffs' frustration about the course of conduct that led to their complaint, but note[d] that defendant was merely following the instructions of its principal, DOE." Pet. App. 8a. It added: "The temporary disenrollment of plaintiffs' son no doubt caused a great deal of anxiety and inconvenience to them. If they have any remedy . . . at all, however, it lies in the administrative process, not this civil suit." *Id.*

On appeal, the court of appeals vacated the decision of the district court and remanded for further proceedings. It reached only the question of the district court's jurisdiction.

The court of appeals first rejected removal jurisdiction under "complete preemption," which the court described as a "misleadingly named doctrine that applies when federal law *has occupied a field*, leaving no room for any claim under state law." *Id.* at 2a-3a (emphasis added). The court then concluded that this Court's decision in *Empire* precluded removal because it "holds that federal law does not completely occupy the field of health-insurance coverage for federal workers." *Id.* at 3a.

The court of appeals next addressed jurisdiction under the federal officer removal statute, 28 U.S.C. § 1442(a)(1), which it characterized as allowing "'any person acting under' a federal officer [to] remove a suit that depends on the defendant's following the directions issued by that federal officer." Pet. App. 3a. Rather than credit the district court's finding that HCSC "was merely following the instructions of its principal," *id.* at 8a -- a finding based on a sworn declaration, *see* J.A. 97 -- the court of appeals emphasized Respondents' allegations, including that HCSC "acted unilaterally" in terminating Ms. Pollitt's family coverage. Pet. App. 3a. The court accordingly remanded the case for evidentiary proceedings to determine whether HCSC "did nothing but carry out the Department of Labor's instructions." *Id.* at 3a-4a.

The court of appeals then gave instructions to guide the inquiry on remand. It said that, "[t]o the extent HCSC was doing nothing but following the agency's orders, the case belongs in federal court." *Id.* at 4a. In that event, the court advised that the case "must be dismissed . . . because suits related to a federal agency's health-benefit-coverage decisions must name the Office of Personnel Management or the employing agency rather than the insurance carrier." *Id.* By contrast, the court stated, if there was no specific directive from DOL to change Pollitt's coverage, "this case must be remanded," and if there was no specific DOL directive to recover past benefits, "the claim for precipitate, mistaken recoupment should be remanded." *Id.*

SUMMARY OF ARGUMENT

I. This case raises a federal question under the complete preemption doctrine. Under this Court's

clarifying decision in *Beneficial National Bank v. Andersen*, 539 U.S. 1, 8 (2003), a state court action is completely preempted, and therefore removable to federal court, if federal law provides the exclusive cause of action for the claim asserted. Here, a combination of FEHBA provisions, OPM's regulations, and the APA create an intricate federal enforcement regime for disputes regarding FEHBA-plan enrollment and benefits. Moreover, all of the claims in the original complaint, which was the pleading in effect at the time of removal and is therefore the focus for removal jurisdiction, were cognizable under the federal remedies. Because Respondents sought to compel enrollment in the Plan for their son, they could have, under the federal enforcement scheme, filed an administrative appeal at the employing agency, followed by judicial review against that agency in federal court; likewise, given that they disputed HCSC's decision retroactively to deny benefits to the minor as a result of the enrollment termination, Respondents could have filed an administrative appeal at OPM, followed by judicial review against OPM in federal court.

In light of a variety of considerations, the Court should deem these federal remedies to be exclusive. The complexity of the remedies indicates that they are exclusive, for Congress and OPM would not have created them with such care had they expected alternative state law causes of action to be available. Next, Congress's intent behind FEHBA's express preemption clause signifies that the federal remedies are exclusive. The timing and circumstances surrounding the amendment of the preemption clause show that Congress acted specifically to ensure complete preemption. And the Court's decision in *Empire HealthChoice*

Assurance, Inc. v. McVeigh, 547 U.S. 677 (2006), bolsters exclusivity, both because the Court there stated that FEHBA benefits disputes properly are adjudicated in federal court and because, under the test for the application of federal common law noted in *Empire*, federal substantive law (the application of which is a relevant consideration for determining if a federal remedy is exclusive) governs controversies over enrollment and benefits under the Plan.

II. In the alternative, the federal officer removal statute, 28 U.S.C. § 1442(a)(1), authorizes removal jurisdiction in this case. This statute is liberally construed to effectuate its purpose of protecting the federal government from the interference that might ensue if potentially hostile state courts rule on federal defenses associated with the government's operations. HCSC meets the three requirements for removal under § 1442(a)(1): (1) it was "acting under" a federal officer; (2) the acts underlying the complaint were performed in the course of HCSC's duties; and (3) HCSC has colorable federal defenses.

HCSC has the requisite "triggering relationship" that allows it to invoke the statute as someone "acting under" a federal officer because its administration of the government's health benefits program for federal employees is "an effort to *assist*, or to help *carry out*, the duties or tasks of the federal superior." *Watson v. Phillip Morris Cos.*, 551 U.S. 142, 149, 152 (2007). Congress established the FEHBA program as a joint effort in which OPM is the chief actor that, among other things, determines benefits and enrollment criteria, issues regulations, and contracts with private carriers for day-to-day administration. The carrier's

administration role includes implementing the government's enrollment directives and making initial benefit determinations that are subject to review and final decision by OPM.

HCSC acted under color of federal office because there is a causal connection between the acts underlying Respondents' allegations and HCSC's performance of its duties. Taking actions concerning enrollment and benefit determinations are at the core of HCSC's contractual obligations under the Plan.

HCSC has at least three colorable federal defenses: (1) conflict preemption based on the incompatibility of state law claims with the federal rules and procedures for resolving enrollment and benefits disputes; (2) express preemption under 5 U.S.C. § 8902(m)(1); and (3) sovereign immunity because the relief sought by Respondents would expend itself on the federal Treasury.

ARGUMENT

The jurisdictional questions presented in this case arise in the removal setting. To determine whether removal jurisdiction exists, the federal courts are "to look at the case as of the time it was filed in state court." *Wis. Dep't of Corr. v. Schacht*, 524 U.S. 381, 390 (1998). "[T]he plaintiff's complaint is controlling," and an "amendment of [the] pleadings . . . does not deprive the district court of jurisdiction." *St. Paul Mercury Indem. Co.* v. *Red Cab Co.*, 303 U.S. 283, 291, 292 (1938). In this case, the original complaint (and, in any event, the second amended complaint as well) fell within the federal courts' removal jurisdiction both because it raised a federal question and because of the federal officer removal statute.

I. Removal Jurisdiction Exists Because the Case Raises a Federal Question

A. Under the Complete Preemption Doctrine, There Is a Federal Question if an Exclusively Federal Cause of Action Is Available for the Claims Asserted

The district court got it right, and the court of appeals got it wrong: HCSC properly removed this case because the suit raises a federal question. Under 28 U.S.C. § 1441(a), removal jurisdiction extends to state court suits over which "the district courts of the United States have original jurisdiction," such as federal question cases under 28 U.S.C. § 1331. Further, if one claim in a state court case raises a federal question and is therefore removable, the federal court has supplemental jurisdiction to adjudicate any other claims. *See* 28 U.S.C. §§ 1367, 1441(c); *City of Chicago v. Int'l College of Surgeons*, 522 U.S. 156, 164-65 (1997).

The general rule is that federal question jurisdiction is determined under the "well-pleaded complaint" rule. *See, e.g., Rivet v. Regions Bank*, 522 U.S. 470, 475 (1998). Therefore, "a case may not be removed to federal court on the basis of a federal defense." *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 14 (1983). One "exception," however, is the "complete pre-emption" doctrine. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 207 (2004). "'[W]hen a federal statute wholly displaces the state-law cause of action through complete pre-emption,' the state claim can be removed." *Id.* (quoting *Beneficial Nat'l Bank v. Anderson*, 539 U.S. 1, 8, (2003)). "Although federal preemption is ordinarily a defense, 'once an area of state law has been completely pre-empted, any claim

purportedly based on that pre-empted state-law claim is considered, from its inception, a federal claim, and therefore arises under federal law.'" *Rivet*, 522 U.S. at 476 (quoting *Caterpillar, Inc. v. Williams*, 482 U.S. 386, 393 (1987)).

The Court first authorized removal under complete preemption in *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557 (1968), which involved claims governed by the Labor Management Relations Act ("LMRA"), 29 U.S.C. § 185. Next, the Court found that the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, can completely preempt state law claims. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 65-66 (1987); *see, e.g., Aetna*, 542 U.S. at 214. Most recently, the Court found that the National Bank Act, 12 U.S.C. §§ 85-86, completely preempts state law usury claims against national banks. *Beneficial Nat'l Bank*, 539 U.S. at 9-11.

Beneficial National Bank, now the leading decision on complete preemption, established what even the dissenters in that case termed a "straightforward" test for removal under the doctrine. *Id.* at 16 (Scalia, J., dissenting). There, the Court explained that, in light of the "framework" adopted in *Avco* and *Metropolitan Life*, "the dispositive question" was "[d]oes the National Bank Act provide *the exclusive cause of action* for usury claims against national banks?" *Id.* at 9 (emphasis added). "If so, then the cause of action necessarily arises under federal law and the case is removable." *Id.* "If not, then the complaint does not arise under federal law and is not removable." *Id.*

In concluding that the National Bank Act set forth an exclusively federal remedy for usury claims, the

Court looked to the statutory framework and other sources. The Court noted that the statute contained a substantive provision specifying what constitutes a usurious level of interest for national banks and a second remedial provision mandating forfeiture and allowing a person who pays excessive interest to recover double the amount by filing "an action in the nature of an action of debt." *Id.*; *see* 12 U.S.C. § 86. Then the Court stated that it had previously "endorsed" the exclusivity of the federal remedy in its precedents by holding "that 'federal law . . . completely defines what constitutes the taking of usury by a national bank, referring to the state law only to determine the maximum permitted rate.'" 539 U.S. at 10 (quoting *Evans v. Nat'l Bank of Savannah*, 251 U.S. 108, 114 (1919)). Finally, the Court emphasized the policy necessity for exclusivity, stating that "[u]niform rules limiting the liability of national banks and prescribing exclusive remedies for their overcharges are an integral part of a banking system that needed protection from 'possible unfriendly State legislation.'" *Id.* (quoting *Tiffany v. Nat'l Bank of Mo.*, 85 U.S. (18 Wall.) 409, 412 (1874)).

Because the National Bank Act "provide[s] the exclusive cause of action for such claims," the Court concluded, "there is . . .no such thing as a state-law claim of usury against a national bank." 539 U.S. at 11. Accordingly, "[e]ven though the complaint makes no mention of federal law," the case "only arises under federal law" and can "be removed under § 1441." *Id.*

B. Federal Law Establishes Exclusive Causes of Action for the Claims Here Asserted

The dispositive question, then, in a case in which a defendant removes based on complete preemption is whether "federal law provides the exclusive cause of action for the claim asserted." *Beneficial Nat'l Bank*, 539 U.S. at 8. For purposes of analysis here, the question divides into three parts: (1) does federal law provide a relevant cause of action? (2) do the claims asserted by Respondents fit that cause of action? and (3) if so, is the cause of action exclusive?

1. FEHBA, in Conjunction with the Administrative Procedure Act, Establishes Causes of Action for Enrollment and Benefits Disputes

Federal law authorizes two remedies relevant to this case: one for disputes about enrollment and one for disputes concerning benefits.

With respect to enrollment, Congress in FEHBA delegated to OPM the authority to prescribe regulations (*see* 5 U.S.C. § 8913(b)), which specify a detailed administrative process for disputes over enrollment. *See* 5 C.F.R. § 890.104. The relevant agency's employing office makes an initial decision regarding enrollment matters, an aggrieved party may seek reconsideration from the agency, and the agency must issue a final decision setting forth its findings. *See supra* p. 4. After that, an aggrieved individual may commence "[a] suit to compel enrollment" against the employing office of the relevant agency. 5 C.F.R. § 890.107(a). FEHBA's jurisdictional section expressly authorizes that suit to be brought in federal court. 5 U.S.C. § 8912.

The precise cause of action available in the suit to compel enrollment is a judicial review claim under the APA. *See* 5 U.S.C. §§ 701-06. The APA presumptively applies whenever an aggrieved party challenges final federal agency action. *See Japan Whaling Ass'n. v. Am. Cetacean Soc'y*, 478 U.S. 221, 230 (1986) ("A separate indication of congressional intent to make agency action reviewable under the APA is not necessary; instead, the rule is that the cause of action for review of such action is available absent some clear and convincing evidence of legislative intention to preclude review."); *accord Clarke v. Sec. Indus. Ass'n*, 479 U.S. 388, 396 n.9 (1987).

With regard to benefits disputes, Congress in 5 U.S.C. § 8902(j) instructed OPM to adjudicate individual grievances over benefits. Under the administrative regime established by OPM, carriers make initial benefits determinations, and the enrollee may seek reconsideration from the carrier and then file an administrative appeal with OPM. *See supra* p. 5. Once OPM issues a final decision, the enrollee, if still aggrieved, "may seek judicial review" under the APA, but that suit "must be brought against OPM and not against the carrier or the carrier's subcontractors." 5 C.F.R. § 890.107(c). Again, because of FEHBA's jurisdictional section, the federal courts have jurisdiction over the lawsuit against OPM. *See Muratore v. OPM*, 222 F.3d 918, 920 (11th Cir. 2000) ("We review OPM's actions pursuant to the FEHBA under the Administrative Procedure Act"); *accord Bryan v. OPM*, 165 F.3d 1315, 1318-19 (10th Cir. 1999).

2. The Federal Remedies for Enrollment and Benefits Disputes Apply to the Claims Asserted in This Case

On enrollment, the original complaint, filed just after termination of the minor's coverage, alleged that Ms. Pollitt had family coverage under the Plan and that HCSC wrongfully "removed her minor child . . . from coverage"; additionally, the original complaint sought a court order "directing Defendant to provide medical coverage for Plaintiffs' minor child." J.A. 81. Respondents could have used the federal remedy to pursue their enrollment grievance -- filing an administrative claim at Ms. Pollitt's employing agency under 5 C.F.R. § 890.104, followed by a federal suit to compel the minor's enrollment if no administrative relief was forthcoming.

As to benefits, the original complaint alleged that HCSC "deemed to be improper" the payments made on the minor's behalf during the retroactive period and insisted that the benefits "would have to be returned." J.A. 78, 79. Respondents requested, in their prayer for relief, that a court "[e]nter judgment for Plaintiffs and against Defendant, directing Defendant to honor all medical insurance claims for their minor child . . . for the period of time from June 16, 1993 to July 30, 2007." *Id.* at 81. Because HCSC had determined that benefits should not be paid for the retroactive period, Respondents were entitled to file an appeal with OPM under 5 C.F.R. § 890.105 to challenge that benefits determination and, if unsuccessful, to seek "judicial review of OPM's final action on the denial of [the] health benefits claim[s]." *Id.* § 890.107(c).

The last category of claims in the original complaint alleged bad faith by HCSC in its handling of the enrollment and benefits matters (J.A. 79), and these allegations too are subject to the federal remedies for enrollment and benefits controversies. This Court, in other benefits contexts, has consistently refused to permit litigants to avoid otherwise applicable federal remedies by recasting their claims in tort. For instance, in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), the Court held that ERISA's remedies completely preempted state law tort claims deriving from benefits denials. The Court explained that "distinguishing between pre-empted and non-pre-empted claims based on the particular label affixed to them would 'elevate form over substance and allow parties to evade' the pre-emptive scope of [the federal statute] . . . simply 'by relabeling their contract claims as claims for tortious breach of contract.'" *Id.* at 214 (quoting *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 211 (1985) (LMRA context)); *see also United Steelworkers v. Rawson*, 495 U.S. 362, 371 (1990) (LMRA context).

The Court should apply the same principle in the FEHBA setting. Here, the original complaint's bad faith allegations are just a different gloss on the challenges concerning enrollment and retroactive benefits denials. Respondents rely on the same predicate facts, add some averments that HCSC engaged in "intentional, willful and wanton acts," and then request compensatory and punitive damages. J.A. 81-82; *cf. Allis-Chalmers*, 471 U.S. at 219 ("nearly any alleged willful breach of contract can be restated as a tort claim for breach of a good-faith obligation under a contract"). Since the tort claim is "derivative" of the

claims challenging the enrollment and benefits determinations, it must be subject to the very same remedies. *Id.*[1]

3. The Federal Remedies for Enrollment and Benefits Disputes Are Exclusive

The next inquiry is whether the federal remedies for FEHBA enrollment and benefits grievances, which apply to Respondents' claims, are exclusive. The Court in *Beneficial National Bank* did not establish a rigid formula for determining when a federal cause of action shall be deemed exclusive. There, for its exclusivity finding, the Court relied on its prior constructions of the statute and the need for uniform regulation of national banks. Elsewhere, in *Avco*, the Court rested on the LMRA's jurisdictional provision to find complete preemption, *see* 390 U.S. at 559; in *Metropolitan Life*, the Court relied on ERISA's legislative history indicating that Congress sought to copy the jurisdictional rules applicable to the LMRA. *See* 481 U.S. at 65-66.

Just as with the federal remedies under the National Bank Act, the LMRA, and ERISA, the federal causes of action with respect to FEHBA enrollment and benefits

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[1] Though we here have centered on the original complaint, given that the allegations at the time of removal govern for removal jurisdiction purposes, the claims in the second amended complaint equally fall within the scope of the federal causes of action. The second amended complaint continued to assert wrongful benefits denials, maintaining that HCSC has not halted efforts to recoup benefits. J.A. 130. And the rest of the allegations address the bad faith claim. *Id.* at 128-30. Hence, the jurisdictional analysis would be the same even if the currently operative pleading were the focus.

disputes are exclusive. Their exclusivity derives from the statute's delegation of authority to OPM, OPM's detailed regulations creating administrative procedures, the APA, and FEHBA's jurisdictional section -- all of which combine to form an intricate enforcement scheme that cannot countenance alternative remedies. Congress's intent with respect to FEHBA's express preemption clause also strongly favors a finding that the federal remedies are exclusive. *See Metropolitan Life*, 481 U.S. at 66 ("[T]he touchstone of the federal district court's removal jurisdiction is . . . the intent of Congress."); *see also Beneficial Nat'l Bank*, 539 U.S. at 9 (the "proper inquiry focuses on whether Congress intended the federal cause of action to be exclusive"). In addition, this Court's decision in *Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677 (2006), confirms the exclusive nature of the federal remedies.

Before turning to the indicia of exclusivity, it helps set the stage to note that every lower court recently to have addressed the issue has held that the FEHBA enforcement scheme is exclusive. *E.g.*, *Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 398 (9th Cir. 2002); *Bryan*, 165 F.3d at 1318-19; *Kight v. Kaiser Found. Health Plan of the Mid-Atl. States, Inc.*, 34 F. Supp. 2d 334, 342 (E.D. Va. 1999); *Bridges v. Blue Cross & Blue Shield Ass'n*, 935 F. Supp. 37, 41 (D.D.C. 1996). The court of appeals in this case did not think otherwise. It said that -- if a jurisdictional basis could be found -- Respondents' case should be dismissed because their suit, under OPM's regulations, "*must* name as the defendant the Office of Personnel Management or the employing agency rather than the insurance carrier" (Pet. App. 4a (emphasis added)), a

signal that the court of appeals recognized the FEHBA administrative scheme plus judicial review as the only available enforcement mechanism. The court of appeals went astray only because it miscomprehended the complete preemption test by focusing on occupation of a field rather than exclusivity. *See infra* pp. 33-34.

a. The Relevant Statutory Provisions and Regulations Creating the Federal Remedies Compel Exclusivity

FEHBA's civil enforcement regime is "complex," interweaving various statutory and regulatory provisions. *Botsford*, 819 F.3d at 396. The starting point is Congress's delegation of authority to OPM not just to "prescribe regulations necessary to carry out [FEHBA]," 5 U.S.C. § 8913(a), but even more specifically on enrollment to "prescribe the time at which and the manner and conditions under which an employee is eligible to enroll." *Id.* § 8913(b). On benefits, Congress provided that "each [FEHBA] contract . . . shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as *the Office* considers necessary or desirable." *Id.* § 8902(d) (emphasis added). Still further, Congress amended FEHBA in 1974 to require that "[e]ach [FEHBA] contract shall require the carrier to agree to pay for or provide a health service or supply in an individual case if *the Office* finds that the employee [or] . . . family member . . . is entitled thereto under the terms of the contract." *Id.* § 8902(j) (emphasis added); *see* Pub. L. 93-246, § 3 (1974).

OPM has responded to Congress's instructions with detailed regulations, including the administrative

remedies for enrollment and benefits grievances. In establishing those remedies, OPM plainly sought to implement Congress's intent. For example, at the time it established the current regime for administrative review of benefits denials, OPM said: "The legislative history of § 8902(j), title 5, United States Code, shows that Congress intended OPM (at that time the Civil Service Commission) to provide an administrative appeal process, binding upon the carriers, that would save covered individuals the expense and delay of being forced into the courts to recover on meritorious claims for benefits." 60 Fed. Reg. 16,037 (1995) (interim regulations); *see also* H.R. Rep. No. 93-459, at 7 (1973); 61 Fed. Reg. 15,177 (1996) (final regulations). OPM added: "Based upon this directive and its central role in the administration of the FEHB Program, OPM established a detailed administrative review process for benefits claims leading to a final decision on such claims by OPM." 60 Fed. Reg. at 16,037.

With the establishment of those administrative review mechanisms for enrollment and benefits grievances (within the employing agency for the former, and within OPM for the latter), Congress and OPM collectively triggered the presumptively applicable APA right to judicial review where disputes remain after completion of the respective administrative processes. *See supra* p. 18; *see also* 60 Fed. Reg. at 16,037 (OPM noting that its final decisions on benefits claims would be subject to "court review" and would be "upheld unless the court concludes that the OPM decision affirming the carrier's denial of benefits was inconsistent with the standard for a final agency action *under applicable Federal law*.") (emphasis added). FEHBA's jurisdictional section, 5 U.S.C. § 8912, completes the

enforcement scheme by providing that judicial review actions may occur in two federal forums (the district courts or the Court of Federal Claims).

What emerges from these statutory and regulatory provisions is a cohesive, workable, federal mechanism for resolving enrollment and benefits controversies. The remedial regime is consistent with Congress's desire that OPM take the lead under the FEHBA program; it helps avoid court litigation through administrative processes; it takes into account the traditional APA mechanism for review of agency action; and, where litigation is required, the litigation is necessarily against the United States and therefore within the confines of the jurisdictional section that Congress enacted.

Against this backdrop, it would make no sense to deem the remedial regime anything but exclusive. Congress and OPM would not have gone to such lengths to create the FEHBA enforcement scheme if they expected state law causes of action likewise to be available. Were state law claims an alternative, the administrative process might never be invoked; the employing agencies under OPM's regulations (on enrollment) or OPM itself (on benefits) would not have opportunity to exercise their expertise, replaced instead by juries deciding enrollment and benefits matters under state law; and FEHBA's jurisdictional section would not at all come into play.

Indeed, state law would likely be the *preferred* enforcement vehicle. State law usually offers lucrative monetary relief and other penalties for infractions in insurance situations (as Respondents, in fact, seek), whereas the FEHBA enforcement scheme provides

limited relief, such as limiting "the recovery . . . to a court order directing OPM to require the carrier to pay the amount of benefits in dispute." 5 C.F.R. § 890.107(c)). Furthermore, the APA does not permit the award of monetary relief. *See* 5 U.S.C. § 706 (APA authorizing court to "hold unlawful and set aside" agency action).[2]

And OPM certainly has made obvious its view that the federal remedies for FEHBA enrollment and benefits cases are exclusive. Its regulations state that the lawsuit against the employing agency on enrollment "*must* be brought against the employing office." 5 C.F.R. § 890.107(a) (emphasis added). Its rules on benefits cases state that lawsuits "*must* be brought against OPM and not against the carrier or the carriers subcontractors." *Id.* § 890.107(c) (emphasis added). OPM contemplates just one remedy: suits against the government presumptively governed by the APA. Having opined in published regulations, after notice-and-comment rulemaking invited by Congress (*see* 5 U.S.C. § 8913(a)), OPM's views are entitled to deference. *See United States v. Mead Corp.*, 533 U.S. 218, 229-30 (2001).

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[2] To suggest that Congress intended to allow state court causes of action is even more curious in light of ERISA, where Congress created an exclusive federal remedy (recognized in *Metropolitan Life* as completely preemptive) that routes health benefits disputes between private employer plans and their participants into federal court. It would be anomalous for Congress then to leave the government's own health benefits controversies to the vagaries of state law and state courts.

b. Congressional Intent Underlying the Preemption Provision Supports the Federal Remedies' Exclusivity

The Congressional intent underlying FEHBA's preemption provision, 5 U.S.C. § 8902(m)(1), further bolsters the conclusion that the FEHBA enforcement scheme is exclusive. In *Empire*, the Court held that the preemption clause, on its own, is "not sufficiently broad to confer federal jurisdiction" over a suit by the carrier seeking a portion of an enrollee's state court tort recovery as reimbursement for earlier-paid benefits. 547 U.S. at 698. Instead, the provision's "unusual" focus on contract terms as the basis for preemption necessitates a "cautious" and "modest" interpretation. *Id.* at 697, 698.

Nonetheless, the circumstances surrounding the preemption provision's most recent amendment provide support for deeming the *federal causes of action for contesting FEHBA enrollment and benefits determinations* to be exclusive and thus "jurisdiction-conferring." *Id.* In fact, in *Beneficial National Bank*, the Court said it would set the standard too high to inquire specifically "whether Congress intended that the cause of action *be removable*," as opposed to just "whether Congress intended the federal cause of action to be exclusive." 539 U.S. at 9 n.5 (emphasis added). Yet, in the FEHBA context, there is, through the preemption provision's amendment, specific intent of Congress's desire to make removable to federal court disputes over enrollment and benefits. Given that Congress and OPM have elsewhere established the federal remedies that provide a basis for complete preemption (remedies that were not at issue in *Empire*, *see infra* p.

30), the Court should honor the legislative intent on removability displayed at the time of the preemption clause's amendment by recognizing the remedies as exclusive and thereby capable of complete preemption.

Though FEHBA did not contain a preemption section when enacted in 1959, Congress added one in 1978. As originally adopted, the section stated:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans *to the extent that such law or regulation is inconsistent with such contractual provisions.*

5 U.S.C. § 8902(m)(1) (1994) (emphasis added). With this provision, Congress intended "to establish uniformity in benefits and coverage under the Federal employees' health benefits program." S. Rep. No. 95-903, at 2 (1978), *reprinted in* 1978 U.S.C.C.A.N. 1412, 1413.

Over time, several courts pointed to the text of FEHBA's preemption clause as a basis for *rejecting* complete preemption. *E.g., Goepel v. Nat'l Postal Mail Handlers Union*, 36 F.3d 306 (3d Cir. 1994); *Arnold v. Blue Cross & Blue Shield of Tex., Inc.*, 973 F. Supp. 726 (S.D. Tex. 1997); *Transitional Hosps. Corp. v. Blue Cross & Blue Shield of Tex., Inc.*, 924 F. Supp. 67 (W.D. Tex. 1996). These courts saw the clause's closing phrase preserving state law not "inconsistent" with FEHBA contract terms as narrowing language incom-

patible with the *complete* preemption of state law. In particular, the decisions rejected analogies to complete preemption under ERISA, on the ground that the ERISA preemption clause contains no proviso exempting from preemption state laws not inconsistent with the statute. *See, e.g., Goepel*, 36 F. 3d at 312 & n.7; *Arnold*, 973 F. Supp. at 731-32; *Transitional Hosps.*, 924 F. Supp. at 70; *see generally* 29 U.S.C. § 1144(a)(1) (ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan").

These decisions sent Congress back to the drafting table. In 1998, it amended FEHBA's preemption clause to take out the final phrase requiring inconsistency between state law and FEHBA contract provisions. Congress explained that the amendment "broadens the preemption provisions in current law to strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live." H.R. Rep. No. 105-374, at 9 (1997). Alluding to its concern over the court decisions that had rejected complete preemption, Congress said: "The amendment confirms the intent of Congress . . . that FEHB program contract terms which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) *completely displace* State or local law relating to health insurance or plans." *Id.* at 16 (emphasis added). In the same vein, Congress added that the "change will strengthen the case for trying FEHB program claims disputes in Federal courts rather than State courts." *Id.* at 9.

Accordingly, "legislative history from the amendment of FEHBA's preemption clause strongly supports con-

gressional intent to create complete preemption, which includes displacement [of state law remedies]." *Botsford*, 314 F.3d at 399; *see also Beneficial Nat'l Bank*, 539 U.S. at 8 (referencing *Metropolitan Life*'s reliance on unambiguous intent shown in "the legislative history of ERISA" to achieve complete preemption). While Congress might have used a different tactic to reach its goal if it could have foreseen this Court's later decision in *Beneficial National Bank*, it acted reasonably in trying to achieve complete *preemption* by amending the *preemption* provision that had been identified by courts as an obstacle to that goal. As it did with ERISA's efforts to copy the LMRA, this Court should give effect to Congress's intent and recognize FEHBA's enrollment and benefit remedies as exclusive ones that justify complete preemption.

c. *Empire* Supports a Finding that the Federal Remedies Are Exclusive

The Court's decision in *Empire* supports the exclusivity of the federal remedies for FEHBA enrollment and benefits grievances. In *Empire*, the Court held that there was no federal jurisdiction over a FEHBA plan's reimbursement claim, which is a species of subrogation claim, against an enrollee. A central reason for the Court's rejection there of federal jurisdiction was that the FEHBA enforcement scheme did not "extend" to "reimbursement claims between carriers and insured workers." 547 U.S. at 696.

But the Court was careful to distinguish reimbursement actions from claims to which FEHBA's remedies *do* apply. With respect to benefits disputes, the Court noted:

> FEHBA's jurisdictional provision, 5 U.S.C. § 8912, opens the federal district-court door to civil actions "against the United States." OPM's regulation, 5 C.F.R. § 890.107(c) (2005), instructs enrollees who seek to challenge benefits denials to proceed in court against OPM "and not against the carrier or carrier's subcontractors." Read together, these prescriptions "ensur[e] that suits brought by beneficiaries for denial of benefits *will land in federal court*."

Empire, 547 U.S. at 696 (last quotation from *Empire HealthChoice Assurance, Inc. v. McVeigh*, 396 F.3d 136, 145 n.7 (2d Cir. 2005)) (emphasis added) (citations omitted).

Thus, the Court in *Empire* anticipated that FEHBA coverage and benefits controversies -- the category of disputes into which Respondents' claims fall -- inevitably "will land" in federal court. That is exactly the result under complete preemption: Enrollment and benefits suits filed in state court become removable to federal court because of the exclusivity of FEHBA's enforcement regime. Consistent with *Empire*, the Court should now hold that the exclusive nature of the available federal remedies "channels disputes over coverage or benefits into federal court." *See id.* at 686-87.

Empire also supports the exclusivity of the federal remedies in a second way. The case for exclusivity and complete preemption is stronger if federal law provides the substantive rules of decision over the controversy. *See Beneficial Nat'l Bank*, 539 U.S. at 11 (because of

need for national uniformity, National Bank Act's provisions "supersede both the substantive and remedial provisions of state usury laws"); *Avco*, 390 U.S. at 560 ("An action arising under [LMRA] § 301 is controlled by federal substantive law even though it is brought in state court"); *Metropolitan Life*, 481 U.S. at 66 (same, under ERISA). In *Empire*, the Court referenced the framework for determining when "a uniform federal common law" will control FEHBA disputes, based on the "pathmarking precedent" in *Clearfield Trust Co. v. United States*, 318 U.S. 363 (1943), and its progeny. *Empire*, 547 U.S. at 690. Under the applicable test, disputes over FEHBA enrollment and benefits *are* governed by federal common law, making exclusive federal remedies all the more necessary.

The *Cle eld* line of decisions mandates that federal common law will control in "areas of uniquely federal interest" where there is a "significant conflict . . . between an identifiable federal policy or interest and the operation of state law." *Empire*, 547 U.S. at 692, 693 (internal quotations omitted). FEHBA enrollment and benefits cases involve "distinctly federal interests" because they "directly affect[] the United States Treasury and the cost of providing health benefits to federal employees." *Id.* at 696, 688; *see also Caudill v. Blue Cross & Blue Shield of N.C., Inc.*, 999 F.2d 74, 77-79 (4th Cir. 1993) (as alternative to complete preemption, finding removal jurisdiction in FEHBA benefits dispute because it is governed by federal common law).

Furthermore, applying state law in FEHBA enrollment and benefits controversies significantly conflicts with Congress's determination that it is *OPM* -- not state courts and juries -- that should regulate enroll-

ment and benefits. *See Botsford*, 314 F.3d at 397-98; *Caudill*, 999 F.2d at 78-79. Relatedly, Congress's delegation of authority to OPM, as well as its enactment of the preemption provision, were designed to "assure uniform coverage and benefits under plans OPM negotiates." *Empire*, 547 U.S. at 686; *see* 60 Fed. Reg. at 16,037 (OPM stating that its regulations establishing the administrative appeals process for benefits disputes "reaffirm the principle of uniformity in the FEHB Program by providing that in judicial disputes regarding the denial of a health benefits claim, review is to be limited to the record that was before OPM and that was the basis of the OPM decision to disallow the benefit"). A necessity for "[u]niform rules" so as to "protect[] from possible unfriendly State legislation" warrants the application of federal substantive law and even "prescribing exclusive remedies." *Beneficial Nat'l Bank*, 539 U.S. at 10 (internal quotation marks omitted); *accord Avco*, 390 U.S. at 559-60.

C. The Court of Appeals' Rejection of Complete Preemption Is Unsound

All of the requirements for complete preemption, consequently, are satisfied in this case: FEHBA's enforcement scheme "creates a federal remedy for [enrollment and benefits disputes] that is exclusive," and Respondents raise "a claim which comes within the scope of that cause of action." *Beneficial Nat'l Bank*, 539 U.S. at 11, 8. The court of appeals reached a contrary conclusion because it erroneously believed that complete preemption depends not on the existence of exclusively federal causes of action, but instead on whether "federal law has occupied a field." Pet. App. 2a.

In contrast to complete preemption, the term "occupation of the field" describes a form of defensive, implied preemption existing where Congress pervasively regulates an area. *See Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992); *California v. ARC Am. Corp.*, 490 U.S. 93, 101 (1989). It does not turn on the existence of a federal remedy, and the Court has not suggested a relationship between the two. The Court has, for example, found occupation-of-the-field preemption in the areas of transportation and sale of natural gas (*see Schneidewind v. ANR Pipeline Co.*, 485 U.S. 293, 310 (1988)), airline noise abatement and airport curfews (*see Burbank v. Lockheed Air Terminal, Inc.*, 411 U.S. 624, 633, 639 (1973)), and alien registration (*see Hines v. Davidowitz*, 312 U.S. 52, 73-74 (1941)). Yet, this Court in *Beneficial National Bank* did not reference any of those decisions, instead remarking that there were only "two categories of cases where this Court has found complete preemption -- certain causes of action under the LMRA and ERISA." 539 U.S. at 8.

The court of appeals also mistakenly believed that *Empire* precluded complete preemption, because supposedly *Empire* holds that "federal law does not completely occupy the field of health-insurance coverage for federal workers." *See* Pet. App. 3a. That observation is irrelevant in the first instance, because it incorrectly looks to occupation of the field, but it is also an erroneous distillation of *Empire*'s teachings. The statement in *Empire* upon which the court of appeals apparently seized -- that is, that FEHBA's preemption provision was not broad enough "completely to displace ordinarily applicable state law, and to confer federal jurisdiction thereby," 547 U.S. at 698

-- was not a pronouncement that FEHBA never can completely preempt state law claims. The statement came only *after* the Court noted that the remedy imposed by FEHBA, the APA, and OPM's regulations for benefits disputes was inapplicable to subrogation matters. Here, the typical route for complete preemption (*i.e.*, the existence of an exclusive cause of action that *is* applicable to the controversy) is available, negating any need to resort to the preemption provision to confer jurisdiction.

II. Removal Jurisdiction Exists Under the Federal Officer Removal Statute

A. The Federal Officer Removal Statute Is Liberally Construed to Advance Its Purpose of Allowing Those Who Assist Federal Officers to Have Their Federal Defenses Heard in Federal Court

Alternatively, the court of appeals' decision must be reversed because removal was proper under the federal officer removal statute, 28 U.S.C. § 1442(a)(1). That statute permits a defendant to remove to federal court an action brought in state court against "[t]he United States or any agency thereof or any officer (*or any person acting under that officer*) of the United States or of any agency thereof, sued in an official or individual capacity *for any act under color of such office*." *Id.* (emphasis added).

The Court has previously summarized the long history of the federal officer removal statute, which dates back to 1815. *See Watson v. Philip Morris Cos.*, 551 U.S. 142, 147-49 (2007); *Willingham v. Morgan*, 395 U.S. 402, 405-06 (1969). The scope of the statute has broadened over time, in a continuing effort to serve its

"'basic' purpose, [which] is to protect the Federal Government from the interference with its 'operations' that would ensue" if state courts, which might be susceptible to "local prejudice," ruled on federal defenses associated with those operations. *Watson*, 551 U.S. at 150 (quoting *Willingham*, 395 U.S. at 406). Section 1442(a)(1), therefore, is "an incident of federal supremacy" designed "to provide a federal forum for cases where federal officials must raise defenses arising from their official duties." *Id.* at 405; *see Arizona v. Manypenny*, 451 U.S. 232, 241 (1981).

From the beginning, Congress recognized that the jurisdictional protection of this statute would be incomplete if it were limited only to persons who are formally federal government officers. The government "can act only th- -gh its officers and agents." *Tennessee v. Davis*, 100 U.S. 257, 263 (1880). In many situations, practicalities demand that private persons be enlisted to assist government officers. If those persons are not afforded the "protection of a federal forum" like federal employees (*Willingham*, 395 U.S. at 407), the removal statute's underlying purpose of avoiding interference with government operations would be defeated simply because of a sub-delegation of authority. *See, e.g.*, *Colorado v. Symes*, 286 U.S. 510, 517 (1932) (removal statute needed "to maintain the supremacy of the laws of the United States by safeguarding officers and others acting under federal authority" against potential state court obstruction). Hence, the original 1815 statute authorized removal by federal customs officers and "any other person aiding or assisting" them. Customs Act of 1815, ch. 31, § 8, 3 Stat. 195, 198; *see Watson*, 551 U.S. at 148. And the current version of the statute authorizes removal by a

federal officer "or any person acting under that officer." 28 U.S.C. § 1442(a)(1).

To obtain removal under § 1442(a)(1), a defendant must demonstrate that it satisfies three basic requirements. The first requirement examines the defendant's status -- that is, whether the defendant falls within the class of persons covered by the statute. If the defendant is a federal officer, this requirement is automatically satisfied. In the case of a private entity, however, the defendant must show that it is a "person acting under" a federal officer. As stated in *Watson*, the words describing this "triggering relationship between a private entity and a federal officer" are "broad," albeit not "limitless." 551 U.S. at 149-50. Generally, the defendant must show that it is involved in "an effort to *assist*, or to help *carry out*, the duties or tasks of the federal superior." *Id.* at 152. The statute therefore does not extend to "a company [that] is subjected to intense regulation," but is not actually assisting the government in carrying out its functions. *Id.* at 153. By contrast, the Court noted approvingly in *Watson* that the lower courts have frequently applied the statute to government contractors that are subject to "detailed regulation, monitoring, or supervision," though the Court there did not have occasion to specify the precise circumstances that give such contractors the necessary status to invoke the statute. *Id.*

The second requirement focuses on the acts that are the subject of the lawsuit in question. The defendant must establish that there is a "'causal connection' between the charged conduct and asserted official authority." *Willingham*, 395 U.S. at 409; *see also Jefferson County v. Acker*, 527 U.S. 423, 432 (1999)

(addressing 28 U.S.C. § 1442(a)(3)); *Maryland v. Soper*, 270 U.S. 9, 33 (1926). This requirement establishes that the removal right does not extend to activities unrelated to the federal duties sought to be protected. For example, a federal border patrol agent may remove a suit charging him with assault for shooting a fleeing suspect who failed to stop on command. *See Arizona v. Manypenny*, 451 U.S. at 240-43. On the other hand, the same border patrol agent would have no right of removal if he were charged with shooting someone in a bar fight while off-duty.

The "causal connection" test is expansive in that it looks only to whether the overall activity was in furtherance of the official duties; "the statute does not require that the prosecution must be for the very acts which the officer admits to have been done by him under federal authority." *Soper*, 270 U.S. at 33. In this regard, the defendants in *Willingham* were federal prison officials who satisfied this requirement by showing that "their only contact with respondent occurred inside the penitentiary, while they were performing their duties." 395 U.S. at 409. It was unnecessary to conduct any further inquiry into the specific acts charged in the complaint before granting removal. Thus, as the Second Circuit has observed, "[t]he hurdle erected by this requirement is quite low." *Isaacson v. Dow Chemical Co.*, 517 F.3d 129, 137 (2d Cir. 2008), *cert. denied*, 129 S. Ct. 1523 (2009). Defendants "must demonstrate that the acts for which they are being sued . . . occurred *because of* what they were asked to do by the Government." *Id.* Moreover, the defendant is required to make a "threshold showing" of connection between the acts and its federal duties, but need not prove its case on the merits in order to obtain re-

moval. *Jefferson County*, 527 U.S. at 432; *see also id.* at 447-48 (Scalia, J., dissenting); *see generally Willingham*, 395 U.S. at 409.

The third requirement is that the defendant have a "colorable federal defense." *Jefferson County*, 527 U.S. at 431; *see Mesa v. California*, 489 U.S. 121, 129 (1989). This requirement flows from the "color of office" language of the statute, and it ties directly to its recognized purpose. *Id.* at 134-35. Since the removal statute is designed to ensure that a defendant will receive fair consideration of federal defenses to which a state court might be hostile, it would not serve the statutory purpose to allow removal where there is no colorable federal defense. In addition, allowing removal in the absence of a colorable federal defense would raise "serious constitutional doubt" about the basis for federal jurisdiction. *Id.* at 136-39.

The Court has emphasized that the defendant need show only that the defense is "colorable" in order to support removal. Requiring the defendant to show a clearly sustainable defense would be "anomalous" because the purpose of removal is to have the validity of the federal defense considered in federal court, not to decide it before the defendant "can have [the case] removed." *Willingham*, 395 U.S. at 407; *see also Jefferson County*, 527 U.S. at 431.

Overall, the Court has stated that the federal officer removal statute is to be "liberally construed to give full effect" to its purpose of providing a federal forum for the fair consideration of federal defenses. *Colorado v. Symes*, 286 U.S. at 517; *see also Watson*, 551 U.S. at 147. It has admonished that "the policy favoring removal 'should not be frustrated by a narrow, grudging

interpretation.'" *Arizona v. Manypenny*, 451 U.S. at 242 (quoting *Willingham*, 395 U.S. at 407). And this rule of liberal construction applies no matter which of the three requirements is at issue in the case. *See Watson*, 551 U.S. at 147 ("acting under"); *Willingham*, 395 U.S. at 407 ("causal connection"); *Jefferson County*, 527 U.S. at 531 ("colorable federal defense"). Nor does the well-pleaded complaint rule have application under § 1442(a)(1): a case is removable even if federal law arises only by way of defense, particularly since the federal officer removal statute's purpose is, in fact, to provide an unprejudiced forum for the litigation of such defenses. *Mesa*, 489 U.S. at 136-37.

This case satisfies all three requirements of 28 U.S.C. § 1442(a)(1), and the court of appeals therefore erred in rejecting the statute's applicability on the current record.

B. This Case Satisfies the Requirements for a Private Party to Remove a Case Pursuant to the Federal Officer Removal Statute

1. HCSC Is a "Person Acting Under" a Federal Officer

Although the Court in *Watson* did not squarely address the precise circumstances in which a government contractor may remove a case, it noted some considerations that are relevant to that determination. *See Watson*, 551 U.S. at 153-54. Additionally, the courts of appeals have further explored this issue in ruling on specific instances of removal sought by government contractors. *See, e.g., Isaacson*, 517 F.3d at 135-40; *Winters v. Diamond Shamrock Chem. Co.*, 149 F.3d 387, 396-401 (5th Cir. 1998) (cited with approval in *Watson*). Because all of the considerations identified

in these authorities point to the conclusion that HCSC was "acting under" a federal officer, the Court should find that HCSC has the requisite "triggering relationship" with the government to satisfy the first requirement for removal under § 1442(a)(1). *Watson*, 551 U.S. at 149.

The basic inquiry into the nature of the relationship between a private entity and a federal officer focuses on whether the private entity is involved in "an effort to *assist*, or to help *carry out*, the duties or tasks of the federal superior." *Watson*, 551 U.S. at 152. HCSC's relationship with the federal government in connection with the FEHBA program is a paradigm of this sort of assistance relationship. First of all, OPM is the superior in the relationship, for Congress in FEHBA made OPM the chief actor in providing health benefits to federal employees: among other things, the agency negotiates contracts under the FEHBA program with *every* carrier; it selects the benefits in each plan; it has authority from Congress to issue all necessary regulations; it has established enrollment criteria and procedures; and it decides benefits disputes pursuant to express instruction from Congress. *See Empire*, 547 U.S. at 683; *see also* 5 U.S.C. §§ 8952(a), 8982(a) (OPM "establish[es] and administer[s]" supplemental dental and vision benefits for federal employees). Even the front page of each FEHBA plan's benefits brochure states that it is "authorized for distribution by the United States Office of Personnel Management." J.A. 59.

OPM's superior position is also highlighted by its "detailed regulation, monitoring, [and] . . . supervision" of the manner in which FEHBA carriers administer

the FEHBA program. *Watson*, 551 U.S. at 153; *see Burkey v. Gov't Employees' Hosp. Ass'n*, 983 F.2d 656, 658 (5th Cir. 1993) (OPM "superintends" FEHBA program); *accord Muratore v. OPM*, 222 F.3d 918, 920-23 (11th Cir. 2000). OPM, again, reviews the carriers' benefits determinations and has the final word when an enrollee appeals a denial of benefits. Further, FEHBA provides for government oversight of plans, requiring regular reports and giving OPM and the General Accounting Office the authority to audit FEHBA plans. *See* 5 U.S.C. § 8910. Through still another delegation from Congress, OPM "prescribe[s] reasonable minimum standards for health benefits plans . . . and for carriers," 5 U.S.C. § 8902(e), and has issued detailed regulations on the topic. *See* 5 C.F.R. § 890.201-02; 48 C.F.R. § 1609.70. If OPM finds an insurer's performance wanting, it can withdraw approval of that carrier or terminate its contract. *See* 5 C.F.R. § 890.204-05.

Not only is OPM a "federal superior," but the role of the Blue Cross and Blue Shield entities such as HCSC that administer the Plan is properly characterized as "help[ing]" OPM "carry out" its duties of providing health benefits to federal employees. *Watson*, 551 U.S. at 152 (emphasis removed). When FEHBA was enacted, the Civil Service Commission (OPM's predecessor), described the "fundamental concepts underlying [FEHBA]" to include "mak[ing] the Commission responsible for the overall administration of the program while sharing day-to-day operating responsibilities with the employing agencies and the insurance carriers." H.R. Rep. No. 86-957, at 18 (1959) (statement of Civil Service Commission). More specifically, FEHBA authorizes OPM in 5 U.S.C. § 8903(1) to

contract for the "Service Benefit Plan," the single government-wide plan providing through "participating affiliates" health benefits based on provider networks. Pursuant to that statutory directive, OPM contracted with BCBSA and local Blue Cross and Blue Shield companies, including HCSC, to administer the Plan in their respective localities. *See Empire*, 547 U.S. at 682. By filling in the private role necessary to establish the Service Benefit Plan described in § 8903(1), HCSC is "helping the Government to produce an item [here, a service] that it needs." *Watson*, 551 U.S. at 153.

With respect to aiding the government on enrollment, HCSC's task is to carry out the directives of OPM or the employing agencies who are, under OPM's regulations, solely responsible for all enrollment matters. *See supra* pp. 3, 17. Emphasizing the Blue Cross and Blue Shield entities' supporting role on enrollment is the CS 1039 provision stating that "eligibility for coverage . . . shall . . . be determined in accordance *with regulations or directions of OPM* given pursuant to [FEHBA]." J.A. 34 (emphasis added).

On benefits, HCSC similarly plays an assisting role. OPM, to reiterate once more, established its administrative appeal regime for benefits disputes as a result of the Congressional instruction that "*the Office*" determine benefits to which an enrollee is entitled under a FEHBA contract "in an individual case." 5 U.S.C. § 8902(j) (emphasis added). Under OPM's regulations, FEHBA carriers make claims decisions in the first instance, with the enrollee having a right to appeal to OPM. *See supra* p. 18; *see also Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 398 (9th

Cir. 2002) (noting OPM's role as final adjudicator on claims and describing OPM as the "plan administrator" for FEHBA plans). Further underscoring that carriers act under OPM and in furtherance of federal policy, OPM's regulations expressly state that "Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims *under authority of Federal statute* (5 U.S.C. chapter 89)"; OPM is thereafter responsible for "final action" subject to judicial review, and a court's reversal of a benefits denial decision shall result in "a court order *directing OPM to require the carrier* to pay the amount of benefits in dispute." 5 C.F.R. § 890.107(c) (emphasis added).

Last, the Blue Cross and Blue Shield companies meet another variation on the superior/assistant model set forth in *Watson* for determining when a private party is "acting under" a federal officer, because they are "perform[ing] a job that, in the absence of a contract with a private firm, the Government itself would have had to perform." 551 U.S. at 154. FEHBA's legislative history reveals that a primary motivation for enactment was to enable the government to compete in recruitment for workers with private companies who were offering health benefits to their employees. *See* H.R. Rep. No. 86-957, at 2. Congress explained that "[a]vailability of this health protection program to Government employees will be of material assistance in improving the competitive position of the Government with respect to private enterprise in the recruitment and retention of competent civilian personnel so urgently needed . . . [for] essential Government programs." *Id.* Given this identified need, had Congress and OPM not decided to enlist private parties to assist in offering health benefits to

federal employees, the federal government itself surely would have to provide the health benefits coverage and use its own employees to administer the Plan.

Administrators of FEHBA plans, therefore, fall comfortably within the class of private entities covered by § 1442(a)(1), as even the court of appeals here seemed to agree. It did not reject HCSC's invocation of § 1442(a)(1) outright, but instead added a legally erroneous requirement of an evidentiary showing for success on removal. *See infra* p. 55.[3]

2. There Exists the Requisite "Causal Connection" Between the Acts Challenged and the Official Duties with Which HCSC Assists

The Second Circuit correctly has observed that "[t]he hurdle erected by [the 'causal connection'] requirement

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[3] It is also worth noting that lower courts have long recognized the applicability of the federal officer removal statute to the closely analogous class of administrators who act as fiscal intermediaries under Medicare. *See Peterson v. Blue Cross/Blue Shield of Texas*, 508 F.2d 55, 57 (5th Cir. 1975) ("indisputable" that the private administrator was "acting under" a federal officer); *Regional Med. Transp., Inc., v. Highmark, Inc.*, 541 F. Supp. 2d 718, 722-25 (E.D. Pa. 2008); *Neurological Assocs. v. Blue Cross/Blue Shield of Fla., Inc.*, 632 F. Supp. 1078, 1080 (S.D. Fla. 1986); *Group Health, Inc. v. Blue Cross Ass'n*, 587 F. Supp. 887, 889-91 (S.D.N.Y. 1984). And notably, even a district court that took an unusually restrictive view of the statute's applicability to government contractors in denying removal to a manufacturer of Agent Orange recognized that private entities providing health insurance through government programs should be eligible for removal because they "act as continuing conduits for government policy." *Ryan v. Dow Chem. Co.*, 781 F. Supp. 934, 951 (E.D.N.Y. 1992).

is quite low." *Isaacson*, 517 F.3d at 137. The defendant need show only that the acts that are the subject of the complaint occurred in the course of the defendant's performance of its official duties -- whether as a federal officer or as a private entity helping to carry out the duties of a federal superior -- rather than in the course of activity unconnected to the official duties.

The leading case on this prong of the § 1442(a)(1) test is *Willingham*, where the defendants were federal prison officials charged with assaulting and torturing an inmate. *See* 395 U.S. at 403. Although the charged acts clearly would not have been appropriate actions for such officials, and thus would not have been necessary to discharging their official duties, the Court held that the officials could remove the case to federal court under § 1442(a)(1). The defendants asserted without contradiction that their only contact with the inmate occurred within the walls of the prison in the course of performing their official duties. *Willingham*, 395 U.S. at 407-08. The Court held that this assertion was "sufficient" because the defendants needed to show only "that their relationship to [the inmate] derived solely from their official duties." *Id.* at 409. The inmate, by contrast, had focused on the inappropriateness of the charged acts, arguing that the defendants were on "a frolic of their own which had no relevancy to their official duties as employees or officers of the United States." *Id.* at 407. The Court explained, however, that this argument did not defeat removal because the question whether the officers were discharging their duties or were instead on a "frolic" should be resolved in federal court. *Id.* at 409.

The Court applied this principle again in *Jefferson County*, holding that federal judges could remove an action brought against them by a state county seeking to collect a municipal tax on their judicial earnings. Although the dissent argued that the cause of the lawsuit was the judges' refusal to pay the tax, a refusal that did not further performance of the defendants' official duties, the Court ruled that the "causal connection" test was satisfied. Citing *Willingham*, the Court reasoned that the inquiry must look to the overall "circumstances that gave rise to the tax liability," and the defendants had shown the "essential nexus" because it was the defendants' "holding court in the county and receiving income for that activity" that generated the dispute. *Jefferson County*, 527 U.S. at 433. Notably, although the dissent disagreed with this ultimate conclusion, it agreed that the defendant need not "prove that the act prompting suit is, beyond doubt, an official one." *Id.* at 447 (Scalia, J., dissenting). Rather, the "causal connection" test is satisfied if the defendant identifies "as the gravamen of the suit an act that was . . . closely connected with . . . the performance of his official functions." *Id.*; *see also Soper*, 270 U.S. at 33 ("It is enough that his acts or his presence at the place in performance of his official duty constitute the basis, though mistaken or false, of the state prosecution.").

Under these authorities, this case satisfies the "causal connection" requirement. The acts that form the predicate for Respondents' original complaint (and the second amended complaint) unquestionably occurred in the course of HCSC's performance of its official duties under the Plan. The suit is grounded in HCSC's alleged temporary termination of an enroll-

ment in the Plan and in benefits determinations associated with that enrollment termination. These acts lie at the core of the services that HCSC performs for the government under CS 1039. This lawsuit is entirely a FEHBA dispute in which HCSC is ensnared as a result of the performance of its official duties under the FEHBA program.

3. HCSC Has Colorable Federal Defenses

The Court has emphasized that removal is authorized as long as the defendant has a "colorable" federal defense; the court considering removal need not determine whether the defendant would ultimately prevail on its federal defense. Thus, for example, in *Jefferson County*, the Court held that removal was proper even though it ultimately rejected the defendants' immunity defense on the merits. *See* 527 U.S. at 435-43. The Court explained that one must "credit the [defendants'] theory of the case" for purposes of the jurisdictional inquiry, which entails merely a "threshold showing that the suit is 'for an act under color of office.'" *Id.* at 432. Here, HCSC has at least three federal defenses that are considerably stronger than "colorable" and hence justify removal.

a. HCSC Has a Colorable Defense of Conflict Preemption

Under principles of ordinary conflict preemption, *see Geier v. Am. Honda Motor Co.*, 529 U.S. 861, 873 (2000), HCSC has an overwhelming defense that Respondents' claims in the original (and second amended complaint) conflict with, and are preempted by, FEHBA's enforcement scheme. As already shown, even if put in tort terms, Respondents' claims fit within the dual administrative procedures, followed by judicial

review, for enrollment disputes and benefits grievances. These remedies are not optional: OPM has said that enrollment matters "must" be pursued against the employing agency, and benefits suits "must" be brought against OPM rather than FEHBA contractors. *See supra* pp. 4-5. Both the district court and the court of appeals (when it stated that dismissal was appropriate in the event jurisdiction were sustained) agreed that Respondents' claims are incompatible with the federal remedies (Pet. App. 4a, 7a-8a), and other lower courts in the FEHBA setting have found state law preempted by the federal remedies, under conflict preemption principles. *E.g., Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526, 539 (5th Cir. 2000), *vacated on other grounds*, 536 U.S. 935 (2002), *reinstated in pertinent part*, 314 F.3d 784 (5th Cir. 2003); *Botsford*, 314 F.3d at 396.[4]

b. HCSC Has a Colorable Defense of Express Preemption

HCSC also has a colorable federal defense under FEHBA's preemption provision, which authorizes the terms of FEHBA contracts "which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)" to supersede any state law "which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). The "relates to" language at the

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[4] Closely related to conflict preemption, the court of appeals believed that HCSC also should have available to it the "government contractor" defense, first articulated by this Court in *Boyle v. United Technologies Corp.*, 487 U.S. 500 (1988). *See* Pet. App. 4a (citing *Boyle*). That defense protects from liability under state law government contractors sued for actions taken pursuant to the government's "precise specifications." *Boyle*, 487 U.S. at 512.

front and back of § 8902(m)(1) creates two requirements for express preemption of state law claims: (1) the claim must implicate contract terms that relate to coverage, benefits, or benefits payments; and (2) the claim must invoke state law that relates to health insurance or plans. In light of the 1998 amendment to the preemption section, "state law -- whether *consistent or inconsistent* with federal plan provisions -- is displaced on matters of 'coverage or benefits.'" *Empire*, 547 U.S. 686 (emphasis added).

Satisfying the first condition, Respondents' original complaint implicates at least two provisions in CS 1039 relating to coverage, benefits, or benefits payments. First, Respondents' allegations challenging the temporary termination of the minor's coverage and seeking to compel enrollment directly implicate the contract provision stating that "[a] person's eligibility for coverage . . . [and] effective date of termination or cancellation of a person's coverage . . . shall all be determined in accordance with regulations or directions of OPM given pursuant to [FEHBA]." J.A. 34. HCSC, of course, maintains that the employing agency, to whom OPM's regulations give authority over enrollment, directed the minor's disenrollment. Second, Respondents' averments that HCSC wrongfully sought retroactively to deny benefits for the minor and to recoup amounts previously paid contest HCSC's actions taken pursuant to § 2.3(g) of the contract, which instructs that, "[i]f the Carrier . . . determines that a Member's claim has been paid in error for any reason (except fraud and abuse), the Carrier shall make prompt and diligent effort to recover the erroneous payment to the member from the member, or, if to the provider, from the provider." J.A. 40. The bad faith

allegations, being derivative of the enrollment and benefits challenges, likewise correlate to the same two CS 1039 provisions.

As to the other condition for express preemption, Respondents rest on state law that relates to health insurance or plans. To be sure, Respondents do not reference in their pleadings any specific Illinois statute, or, for that matter, any identifiable common law cause of action. Nevertheless, under this Court's precedents, all that is required -- given the preemption provision's language "relates to . . . plans" -- is that Respondents seek to use state law to dispute HCSC's administration of *a plan*. Interpreting ERISA's nearly identical preemption language under which ERISA preempts state laws that "relate to any employee benefit plan," 29 U.S.C. § 1144(a)(1), the Court has said that "the pre-emption clause is not limited to 'state laws specifically designed to affect employee benefit plans.'" *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983)). Or as the Court has put it in another ERISA case: "Because the court's inquiry must be directed to the plan, th[e] . . . cause of action 'relate[s] to' an ERISA plan"; "there simply is no cause of action if there is no plan." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990).

We recognize that the Second Circuit stated in *Empire* that only state laws specifically directed at health insurance or plans are encompassed within the second part of FEHBA's preemption clause. *See Empire HealthChoice Assurance, Inc. v. McVeigh*, 396 F.3d 136, 146 (2d Cir. 2005); *but see Burkey*, 983 F.2d at 660; *Hayes v. Prudential Ins. Co.*, 819 F.2d 921, 926

(9th Cir. 1987). This Court did not endorse the Second Circuit's view when it affirmed in *Empire*. To the contrary, the Court indicated that § 8902(m)(1) would preempt general state contract law, assuming satisfaction of the first part of the preemption provision. *See* 547 U.S. at 697-98. In any event, at least with respect to their bad faith claim, Respondents should be deemed to have invoked state law specifically aimed at insurance. The Illinois Supreme Court has held that there exists no general tort of bad faith under Illinois law; rather, in insurance situations, a cause of action exists (if at all) solely under the Illinois Insurance Code, 215 Ill. Comp. Stat. 5/155. *See Cramer v. Ins. Exch. Agency*, 675 N.E.2d 897, 904 (Ill. 1996).

c. HCSC Has a Colorable Defense of Sovereign Immunity

HCSC has a colorable defense of sovereign immunity. Because the United States has not consented to be sued under state law for actions taken in connection with FEHBA enrollment and benefit determinations, sovereign immunity would bar Respondents' claims if they were brought directly against the government. *See, e.g., United States v. Nordic Village, Inc.*, 503 U.S. 30, 33 (1992); *United States v. Mitchell*, 463 U.S. 206, 212 (1983). HCSC, of course, is not the government, but in some circumstances sovereign immunity principles can extend to private parties who are essentially standing in the government's shoes. In defining the scope of sovereign immunity, "[t]he general rule is that a suit is against the sovereign if 'the judgment sought would expend itself on the public treasury or domain, or interfere with the public administration.'" *Dugan* v.

Rank, 372 U.S. 609, 620 (1963) (*quoting Land v. Dollar*, 330 U.S. 731, 738 (1947)).

The lower courts have applied this principle in the context of private carriers that provide various types of health insurance on behalf of the government, concluding that they are entitled to sovereign immunity when the public treasury would bear the cost of any recovery. On this front, the courts of appeals have afforded sovereign immunity to Medicare carriers, recognizing that "[t]he United States is the real party in interest" in actions against them "because recovery would come from the federal treasury." *Anderson v. Occidental Life Ins. Co.*, 727 F.2d 855, 856 (9th Cir. 1984); *accord Matranga v. Travelers Ins. Co.*, 563 F.2d 677, 677 (5th Cir. 1977); *Pine View Gardens, Inc. v. Mut. of Omaha Ins. Co.*, 485 F.2d 1073, 1074-75 (D.C. Cir. 1973). And in the state analogue to the situation presented here, one court of appeals has held that suits against carriers administering health benefits plans for state government employees are barred by Eleventh Amendment sovereign immunity because "a judgment would ultimately affect the state treasury." *Shands Teaching Hosp. & Clinics, Inc. v. Beech St. Corp.*, 208 F.3d 1308, 1312 (11th Cir. 2000).

Similarly, in FEHBA litigation, "the real party in interest is the United States" because the federal government bears the financial burden of recoveries involving FEHBA plans. *Empire*, 547 U.S. at 709 (Breyer, J., dissenting); *see also id.* at 684 (majority explaining Plan's finances). Under FEHBA, the government contributes the majority of the premium cost, collects the balance from enrollees, and then deposits the total into a fund in the federal Treasury. *See su-*

pra pp. 3-4. Blue Cross and Blue Shield entities administering the Plan draw directly from the Treasury fund to pay benefits and to be reimbursed for "payments made and liabilities incurred on behalf of FEHB subscribers." J.A. 52; *see* 48 C.F.R. § 1632.170(b). In addition, the government reimburses FEHBA carriers for a variety of administrative expenses, including "legal expenses incurred in the litigation of benefit payments." 48 C.F.R. § 1652.216-71(b)(2)(i)-(ii).[5]

In light of this financial arrangement, the relief sought in this particular FEHBA case would, if granted, "expend itself on the public treasury" and is therefore barred -- or at a minimum colorably can be asserted to be barred -- by the United States' sovereign immunity. *Land v. Dollar*, 330 U.S. at 738.

C. The Court of Appeals Erred in Conditioning Federal Officer Removal on a Finding That HCSC Was Specifically Directed to Perform the Acts in Question, a Standard That in Any Event Was Satisfied Here

The court of appeals rejected federal officer removal jurisdiction on a ground that is entirely inconsistent with this Court's precedent. The court of appeals did not accept that removal is permitted if HCSC's actions occurred in the normal course of administering a government program; rather, it held that removal is

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[5] This is not to say that there is no private insurance component to the FEHBA program. As one example, the Blue Cross and Blue Shield companies carry risk because, in the event the Plan is terminated and the Treasury funds (including contingency reserves) are insufficient to cover all outstanding claims, the companies are responsible for the shortfall. *See Christiansen v. Nat'l Sav. & Trust Co.*, 683 F.3d 520, 530 (D.C. Cir. 1982).

allowed only if "HCSC was doing nothing but following the agency's orders." Pet. App. 4a. Specifically, the court held that if the government "did not direct HCSC to change Pollitt's coverage . . . then this case must be remanded to state court." *Id.* Likewise, with respect to benefits, the court held that if the government "did not direct [HCSC] to recover past benefits from medical providers, then the claim for precipitate, mistaken recoupment should be remanded." *Id.*

The court of appeals erred in requiring these kinds of specific federal directives for the acts, notwithstanding that these acts occurred in the course of HCSC's performance of its administrative duties under the Plan. Most notably, the court of appeals' approach contravenes this Court's earliest jurisprudence concerning federal officer removal. In *Davis v. South Carolina*, 107 U.S. 597 (1883), the defendant charged with murder was an army officer who was enlisted to assist federal marshals in enforcing the revenue laws. The Court held that he could remove the prosecution to federal court even though he was not automatically covered by the statute, which at that time was limited to revenue officers. *Id.* at 600; *see Watson*, 551 U.S. at 148 (describing the federal revenue officer removal statute in effect at the time). The Court explained that the defendant was entitled to the protections of the statute because "he was a person 'who lawfully assist[ed]' a revenue officer 'in the performance of his official duty.'" *Watson*, 551 U.S. at 149 (quoting *Davis*, 107 U.S. at 600). There was no suggestion in *Davis* that the revenue officer had specifically directed the defendant to shoot the suspect, yet the Court held that he was "acting in [the] capacity" of assisting the officer. *Davis*, 107 U.S. at 600.

Similarly, in *Soper*, the state conceded that a chauffeur who was assisting the revenue officers was entitled to the same right of removal simply because he was acting as a "helper to the four officers under their orders and by direction of the Prohibition Director." 270 U.S. at 30. There was no inquiry into any specific directives given to the chauffeur, and certainly no suggestion that he had been directed to commit the murder with which he was charged. *See also Watson*, 551 U.S. at 151 (removal under 28 U.S.C. § 1443(2) available to "private parties 'only' if they were 'authorized to act with or for [federal officers or agents] in affirmatively executing duties under . . . federal law'") (quoting *City of Greenwood v. Peacock*, 384 U.S. 808, 824 (1966)); *Jefferson County*, 527 U.S. at 447 (Scalia, J., dissenting) (defendant need not "prove that the act prompting suit is, beyond doubt, an official one").

In any event, even if the unduly restrictive standard proffered by the court of appeals were correct, that standard is satisfied on the record of this case. HCSC's Notice of Removal was supported by a sworn declaration of a BCBSA employee concerning the events that triggered the dispute in this case. J.A. 96-104. The declaration, which was uncontradicted by any evidence at all by Respondents, recites (with supporting exhibits) that the DOL "instructed [BCBSA and HCSC] on approximately July 18, 2007, to change Ms. Pollitt's enrollment . . . to 'Enrollment Code 104' or Self-only coverage from the date '10-19-03.'" *Id.* at 97. That evidence regarding the enrollment decision (which is wholly consistent with CS 1039's proviso that the government, not carriers, is solely responsible for enrollment) is sufficient to support removal even under the court of appeals' approach, especially given that

the removing party's theory of the case must be credited for purposes of determining the propriety of federal officer removal.

Moreover, § 2.3(g) of CS 1039 specifically *requires* HCSC to pursue recoupment in the case of "erroneous payments," like payments made on behalf of a person who was not actually enrolled. J.A. 40-42. Based on the declaration and the contract, the district court made a factual finding that HCSC "was merely following the instructions of its principal." Pet. App. 8a. Accordingly, even if the court of appeals' erroneous interpretation of the federal officer removal statute were correct, it was unjustified in reversing the district court's order upholding removal without finding "clear error." *See Knowles v. Mirzayance*, 129 S. Ct. 1411, 1421 (2009)).[6]

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[6] The court of appeals erred in suggesting that, if specific direction occurred on enrollment issues but not on benefits recoupment, then the latter automatically should be remanded to state court. *See* Pet. App. 4a. If the Court were to find that the now-moot claims associated with enrollment were the only causes of action to which the federal officer removal statute applied, it would still remain with the district court in its discretion to determine whether to keep the rest of the case. *See* 28 U.S.C. § 1367(c)(3).

CONCLUSION

The Court should reverse the judgment of the court of appeals.

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December 2009

RESPONDENT'S BRIEF

B706
Supreme Court, U.S.
FILED
JAN 25 2010
OFFICE OF THE CLERK

No. 09-38

IN THE
Supreme Court of the United States

HEALTH CARE SERVICE CORPORATION,
Petitioner,

v.

JULI A. POLLITT AND MICHAEL A. NASH,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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QUESTIONS PRESENTED

1. Whether administrative remedies under the Federal Employees Health Benefits Act of 1959 ("FEHBA"), 5 U.S.C. §§ 8901-8914, completely preempt – and therefore make removable to federal court – state-law claims challenging bad-faith insurance practices where (a) FEHBA creates no cause of action in federal court, (b) its administrative remedies are not exclusive and do not encompass bad-faith claims, and (c) other state-law claims that could have been resolved administratively were mooted by petitioner prior to removal.

2. Whether a private company that, as a licensee under a government contract, competes to provide health insurance for the personal use of government employees is "acting under" the control of a federal officer to fulfill a basic governmental function, and whether the company's bad-faith acts are taken "under color of such office," as required for removal under 28 U.S.C. § 1442(a)(1).

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INTRODUCTION

This case involves state-law claims for bad-faith insurance practices. Such cases are brought routinely in state courts, which long have decided federal-law defenses that may pertain to those claims.

Seeking to remove the case from state to federal court, petitioner Health Care Service Corporation ("HCSC") invoked two narrow exceptions to the well-pleaded complaint rule: the judicially created complete preemption doctrine and the federal officer removal statute, 28 U.S.C. § 1442(a)(1). In remanding the case to the district court, the court of appeals properly rejected the complete preemption basis for removal and mandated additional fact-finding for federal officer removal.

The complete preemption doctrine does not apply here for several reasons. Most importantly, Congress did not create any federal cause of action under FEHBA over which federal courts have original jurisdiction. Under this Court's complete preemption precedent, that forecloses HCSC's entitlement to removal. HCSC asks this Court to stretch an administrative remedy created by the federal Office of Personnel Management ("OPM") into a jurisdiction-conferring provision empowering federal courts to hear claims like respondents'. Such an expansion of the complete preemption doctrine finds no support in the logic of complete preemption removal and would conflict with this Court's well-settled precedent that complete preemption removal should be rare and that federal courts lack the power to expand their own jurisdiction through judicially created doctrines. Only Congress can expand federal removal jurisdiction, and it has not done so here.

The federal officer removal statute likewise does not support HCSC's effort to remove this case from state to federal court. That provision's "acting under" and "color of . . . office" requirements cannot be contorted to transform a private insurance carrier into a "federal officer" when it is alleged to have acted outside the scope of its federal contract in causing damage to an enrollee's family. The historical purpose of the statute – to ensure that federal operations would not be stymied by recalcitrant state judicial systems – finds no grounding in the federal health benefits context. And the individual actions that caused respondents to bring this suit – denying coverage precipitously and retroactively, and sending unwarranted recoupment notices to respondents' medical care providers – were actions undertaken by HCSC without the compulsion or instruction of the federal government. In the acts that gave rise to this suit, therefore, HCSC was neither "acting under" a federal officer nor conducting itself "under color of . . . office" of a federal agency.

STATEMENT

1. In 1959, Congress enacted the Federal Employees Health Benefits Act ("FEHBA") to put the federal government on a stronger footing with other employers in the competition for skilled workers. During the preceding decade, "a wide gap" had emerged between the government, which did not offer comprehensive health insurance as an employee benefit, and "[e]nlightened, progressive private enterprise," which "almost universally" did. H.R. Rep. No. 86-957, at 2 (1959). Proponents of the legislation argued that "[t]he addition of [a] health insurance program . . . to the existing fringe benefits package for Government employees" would "place the Govern-

ment on a substantially equal level with progressive industry in respect to employee fringe benefits." *Id.* Such benefits would "be of material assistance in improving the competitive position of the Government with respect to private enterprise in the recruitment and retention of competent civilian personnel." *Id.*

That fringe benefit program is now the largest employer-sponsored health insurance plan in the United States. In 2009, it covered more than eight million federal employees, retirees, former employees, and family members. The federal government offers a choice of approximately 269 insurance plans to its employees, and those plans are administered by approximately 111 carriers.[1] "With a number of options offered by different carriers, rather than one plan administered solely by the government, Congress created a system in which insurers compete vigorously for employees' subscription dollars." *Houston Cmty. Hosp. v. Blue Cross & Blue Shield of Texas, Inc.*, 481 F.3d 265, 271 (5th Cir. 2007) (internal quotations omitted).

Since 1960, the largest of those plans has been the Blue Cross Blue Shield Service Benefit Plan ("Plan"), the terms of which OPM negotiates annually with the Blue Cross Blue Shield Association ("BCBSA"). *See* Pet. Br. 3. HCSC administers the Plan in Illinois as a licensee of BCBSA. *See id.*

2. Respondents Juli Pollitt and Michael Nash are the parents of Michael Pollitt. Ms. Pollitt – an

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[1] *See* Statement of Nancy H. Kichak, Associate Director for Strategic Human Resources Policy, OPM, on FEHBP's Prescription Drug Benefits, Before the House Subcommittee on Federal Workforce, Postal Service and the District of Columbia at 1 (June 24, 2009), *at* http://www.opm.gov/News_Events/congress/testimony/111th Congress/06_24_2009.asp.

employee of the Department of Energy ("DOE") – enrolled in the Plan in 1987. When her son Michael was born in 1993, she added him to her coverage, changing her enrollment status from "Self only" to "Self and family."[2] That change was reflected in HCSC's enrollment records. JA97, 99.

Beginning in October 2003, Ms. Pollitt took a medical leave from DOE. As a result, her employment status transferred from DOE to the Department of Labor ("DOL"). JA97, 102. From then until July 2007, Ms. Pollitt paid all health insurance premiums and submitted claims for herself and Michael. JA77. Until July 30, 2007, Ms. Pollitt had no indication of any problem with Michael's insurance coverage. JA78.

Sometime prior to July 18, 2007, HCSC attempted to reconcile its enrollment records (upon which benefits were paid) with those of DOL (upon which premiums were paid). JA97, 125-26.[3] As part of that process, DOL sent HCSC a form indicating that DOL records listed Ms. Pollitt's coverage status as "Self only." JA97, 100. Across the top of the form is a handwritten date – 10/19/03. JA100.[4]

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[2] In deciding whether the district court had jurisdiction, this Court may consider the allegations in the complaint, the status of the case at the time the notice of removal was filed, and the evidence offered in the district court. *See Pullman Co. v. Jenkins*, 305 U.S. 534, 537-38 (1939); 14C Charles Alan Wright et al., *Federal Practice and Procedure* §§ 3734, 3739 & n.74 (4th ed. 2009) ("Wright").

[3] BCBSA performs these reconciliations on behalf of HCSC. *See* Pet. Br. 3, 6.

[4] One of HCSC's employees asserted that, in this form, DOL "instructed" HCSC to change Ms. Pollitt's coverage to "104" or "Self only" coverage retroactive to October 2003. JA97. This

Upon receiving that form, HCSC made no attempt to clarify the discrepancy between its records and DOL's, either by contacting Ms. Pollitt or by seeking clarification from DOL. JA124-27; *cf.* 5 C.F.R. §§ 890.110 (requiring carrier to compare its enrollment records with quarterly report from each employing office and to request documentation necessary to resolve discrepancies), 890.308(a)(1) (requiring carrier to provide written notice of enrollment discrepancies to individual seeking clarification). Instead, within two weeks of receiving the form indicating a possible discrepancy in enrollment status, HCSC simply terminated coverage for Michael. JA126-28.

Ms. Pollitt first learned of HCSC's actions on July 28, 2007, when she attempted to fill a prescription for Michael and was told by the pharmacist that her insurance would not pay. When Ms. Pollitt called HCSC on July 30 to find out why her claim was denied, she was told that Michael's coverage had been terminated. JA128. No one ever informed her that she had a right to appeal that decision. *Id.*

On August 1, 2007, she received a letter from HCSC enclosing a "new" identification card that supposedly reflected changes she had "recently" made to

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form appears in the record, however, and it contains no such instruction. Instead, it shows that Ms. Pollitt's payroll office (DOL) assigned her enrollment code "104" and appears to note a "Discrepancy" between the payroll office and insurance carrier records. With respect to "Corrective Action," it states only that the carrier is "WAITING FOR FAX RESPONSE." JA100. No contemporaneous fax appears in the record. Below, respondents requested discovery that would have shed light on DOL's role (if any) in resolving the discrepancy, but such discovery has not yet been ordered or provided. JA134-35; *see also* Mem. in Opp. to Def.'s Mot. To Dismiss 6 (Jan. 22, 2008).

her enrollment; the card was for herself only and was backdated to October 2003. JA129.

Meanwhile, HCSC had already sent notices to 10 of Michael's medical service providers, informing them that payments it had made since October 2003 were in error and demanding a refund. JA127. The providers in turn sought payment directly from respondents. *E.g.*, JA106-09, 121. In some cases, those providers threatened to refer the matter to a collection agency. JA137. At least one provider also expressed reluctance to treat Michael and requested cash payments for any future medical services. JA131-32. When respondents began receiving refund requests from providers, they realized that they would be billed – all at once – for the full cost of all the medical care Michael had received over the previous four years. JA131. The prospects of such a financial burden created enormous stress for respondents. *Id.*

3. Respondents filed this suit in the Circuit Court of Lake County, Illinois, on September 10, 2007. JA77. Their original complaint alleged that HCSC had acted in bad faith in administering Michael's coverage and that it was estopped to deny coverage because it had accepted premiums and paid claims for Michael. JA78-80. Respondents sought a judgment directing HCSC to re-enroll Michael in the insurance plan, honor claims for benefits concerning Michael's medical care, and pay damages – including reimbursement for amounts that respondents paid Michael's medical providers, compensation for respondents' emotional distress, and punitive damages. JA81-82.

Soon after the suit was filed, DOE sent a letter to DOL, stating that Ms. Pollitt's coverage included her

family when she was transferred to DOL's rolls and that coverage should have continued after her transfer. JA101-03. On October 3, 2007, HCSC received a copy of that letter. JA97. On October 17, HCSC informed Ms. Pollitt that Michael was being reinstated on her insurance policy and that the refund requests from his medical providers would be rescinded. JA84.

The matter did not end there. Notwithstanding HCSC's assurance that it would "rescind the refund request[s]," JA84, HCSC continued to seek refunds from Michael's doctors and therapists. On November 9, 2007, HCSC sent a letter to Children's Therapy and Rehab Specialists, stating that, "[a]fter reviewing the information you provided regarding a refund request . . . , we determined that . . . we must maintain our original request for [a] refund . . . (Our records indicate that the patient's membership ended on 10/18/2003)." JA107-08.

As HCSC continued to demand payment from the providers, the providers continued to demand payment from respondents. As late as December 11, 2007, Ms. Pollitt received letters with admonitions like: "YOUR ACCOUNT IS PAST DUE!" (JA121), and "If you are unable to pay in full PLEASE SEND PARTIAL PAYMENT" (JA122).

4. On October 22, 2007, HCSC filed a notice of removal to federal district court, citing the doctrine of complete preemption and the federal officer removal statute as bases for jurisdiction. JA85, 90-94. Then, even as it continued to send letters demanding refunds from Michael's doctors, HCSC filed a motion to dismiss, arguing that respondents' claims for reenrollment and benefits became moot prior to removal when Michael's coverage was reinstated and the

refund requests were rescinded. *See* Mem. in Support of Def.'s Mot. To Dismiss 2, 7-9 (Oct. 26, 2007). HCSC also argued that all of respondents' claims were preempted by FEHBA. *See id.* at 9-12.

The district court granted the motion without prejudice, giving respondents leave to amend their complaint. JA105. Respondents filed an amended – and later a second amended – complaint, which dropped the moot claims and focused on their claim for damages caused by HCSC's bad faith. JA110-20, 123-33.

Respondents' second amended complaint alleges that HCSC acted in bad faith by, among other things: failing to take reasonable steps to verify Michael's enrollment status beginning in 2003; failing to make reasonable efforts to find the source of the discrepancy regarding his enrollment when it came to light in 2007; terminating Michael's coverage without prior notice or explanation and without mentioning the right to appeal; choosing to deny Michael coverage retroactively instead of following the usual practice of seeking payment for back premiums; and failing to inform Michael's medical providers that it was no longer seeking refunds from them. JA124-30. Respondents claimed damages for the cost of a substitute insurance policy for Michael while he was not enrolled in HCSC's plan; the additional cost of paying four years' worth of back premiums for Michael at once; emotional distress (including professional treatment for Ms. Pollitt) due to the prospect of having to pay four years' worth of medical bills for Michael; the additional cost of up-front payments to some of Michael's medical providers who are reluctant to treat him given HCSC's conduct; and punitive damages. JA131-32.

HCSC then filed another motion to dismiss on FEHBA preemption grounds, which the district court granted with prejudice. Pet. App. 5a-8a. The court began its analysis by incorrectly stating that respondents' original complaint, which in part sought relief regarding enrollment and benefits, was filed *after* HCSC re-enrolled Michael. *Id.* at 6a. Instead, the complaint was filed first, and the requests for enrollment and benefits relief became moot before the case was removed to federal court. *See supra* pp. 6-7.

On the merits, the district court held respondents' claims preempted under FEHBA. Pet. App. 7a-8a. It also held that respondent Nash lacked standing because, although he was liable for Michael's medical bills, he had no relationship with HCSC. *Id.* at 6a-7a. Finally, it held (without analysis) that the case was properly removed from state court. *Id.* at 7a-8a.

5. On appeal, the Seventh Circuit reversed and remanded. Pet. App. 1a-4a. Without reaching the merits of the dismissal, it held that the district court erred in allowing removal without conducting an evidentiary hearing. The Seventh Circuit first rejected the argument that FEHBA supports removal, relying on this Court's decision in *Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677 (2006), to hold that FEHBA does not completely preempt state law and thus cannot create federal removal jurisdiction. Pet. App. 2a-3a.

The Seventh Circuit next considered whether HCSC had proved that it "act[ed] under" a federal officer, which would authorize removal under 28 U.S.C. § 1442(a)(1). It observed that the parties disputed whether HCSC in fact followed instructions from DOL regarding Michael's coverage. Pet. App. 3a. Given that dispute, it held that "a district judge

cannot accept HCSC's say-so and use that as the basis of removal." *Id.* at 3a-4a. Instead, the Seventh Circuit instructed the district court to conduct an evidentiary "hearing under Fed. R. Civ. P. 12(b)(1)," "make appropriate findings" resolving the dispute, "and then either retain or remand the case as the facts require." *Id.*

SUMMARY OF ARGUMENT

I. FEHBA does not create federal removal jurisdiction through the judicial doctrine of complete preemption of respondents' state-law bad-faith claims. *First*, this Court has found complete preemption only when Congress created an exclusive cause of action in federal court for the claim asserted. FEHBA creates no such cause of action. While some administrative remedies are available under FEHBA and its implementing regulations, the logic of the complete preemption doctrine – which allows removal to federal *court* to pursue an exclusively federal cause of action there – does not extend to administrative remedies. Indeed, there would be nothing for the federal court to do following removal in such a case except to dismiss in favor of the administrative process – a task that state courts are equally capable of performing. Allowing administrative remedies to create complete preemption would substantially expand that narrow exception to the well-pleaded complaint rule, upsetting the jurisdictional balance between state and federal courts.

Second, even if administrative remedies could trigger complete preemption, nothing in FEHBA purports to make such remedies exclusive or to extinguish all state laws touching upon federal employee health benefits. FEHBA's preemption provision is narrow, reaching only state laws relating to certain

terms of health insurance contracts. FEHBA's legislative history confirms the limited preemptive reach of the statute: Congress evinced concern with preempting state laws requiring certain terms in health insurance policies, not with sweeping away all state insurance law. And FEHBA's jurisdictional provision merely gives federal courts concurrent jurisdiction over claims against the United States. This is not a suit against the United States.

Furthermore, nothing in the implementing regulations suggests that the administrative remedial scheme was intended to extinguish state-law claims of bad faith, or even claims regarding enrollment and benefits (which in any event were moot in this case prior to removal).

Nor does this Court's decision in *Empire* help HCSC: it addressed whether a FEHBA carrier's claim filed in federal court raised a federal question, not whether FEHBA authorized removal by completely preempting a state-law claim.

II. The federal officer removal statute also does not support federal jurisdiction here. To avail itself of the exceptional privilege of federal officer removal, a private party must, among other things, be a person "acting under" a federal officer and be sued for acts "under color of . . . office." 28 U.S.C. § 1442(a)(1). Neither condition is satisfied here.

First, this Court need not reach the question whether HCSC is a person "acting under" a federal officer because, as the Seventh Circuit properly concluded, HCSC has not established that it was sued for acts "under color of . . . office." Respondents allege that their injuries resulted from HCSC's bad-faith, unilateral conduct. HCSC contends that it was simply following DOL's direction. Under this Court's

precedent and ordinary principles of removal jurisdiction, that dispute of fact – regarding whether the challenged conduct was undertaken under "color of . . . office" – cannot be resolved simply on the basis of HCSC's naked allegations. The Seventh Circuit therefore correctly remanded this matter to the district court for limited fact-finding.

Second, at a more basic level, contracting to provide health insurance services to federal employees does not constitute "acting under" a federal officer within the meaning of § 1442(a)(1). HCSC was not assisting a federal officer in performing a sovereign, governmental function. The text and structure of the federal officer removal statute establish that, to the extent § 1442(a)(1) applies to private contractors at all, such contractors must be acting on delegated official authority or aiding the performance of a sovereign, governmental function. As this Court noted in *Watson v. Philip Morris Cos.*, 551 U.S. 142 (2007), to have any plausible claim to removal, a contractor must be assisting in performing a sovereign, "governmental" task. That reading of the "acting under" clause is strengthened by the "color of . . . office" clause, which evidences Congress's expectation that those defendants invoking the statute would have some claim to have been clothed with government authority.

Those standards foreclose HCSC's entitlement to removal here. In providing health insurance services to federal employees, HCSC is not acting on delegated authority, and it is not standing in the shoes of a federal officer. The most that can be said is that HCSC was complying with the terms of a contract voluntarily negotiated with OPM respecting the provision of a service to federal employees. The federal

officer removal statute was never intended to apply in such circumstances.

The government unquestionably may act in different capacities – *e.g.*, as regulator, market participant, or employer – and the legal privileges and implications of its conduct vary depending on the capacity in which the government is acting. In contracting for BCBSA and its licensees (including HCSC) to offer health insurance to federal employees, OPM was not engaged in a sovereign, governmental function. It was acting as an employer. Permitting a private contractor to invoke § 1442(a)(1) when it does no more than provide services to the government as an employer would stretch the statute past its breaking point. Virtually all contractors would lay claim to such a removal right. Such an expansion finds no support in the statute's history or purposes.

Finally, HCSC was not "acting under" a federal officer because it was not in a position of subordination to or control by a federal officer. Although HCSC goes to great lengths to show that it was acting under detailed and specific control of federal officers, the reality is that HCSC was acting according to voluntarily negotiated contract terms. Such a relationship cannot support removal.

ARGUMENT

Federal courts are courts of limited jurisdiction. *See* U.S. Const. art. III, § 2, cl. 1; *Ex parte Bollman*, 8 U.S. (4 Cranch) 75, 93 (1807). "'[T]wo things are necessary to create jurisdiction . . . . The Constitution must have given to the court the capacity to take it, and an act of Congress must have supplied it. . . . To the extent that such action is not taken, the power lies dormant.'" *Finley v. United States*, 490 U.S. 545, 547-48 (1989) (quoting *The Mayor v. Cooper*, 73 U.S. (6 Wall.) 247, 252 (1868)) (emphasis omitted). Accordingly, federal jurisdiction should be "scrupulously confine[d] . . . to the precise limits which [a] statute has defined" to ensure "[d]ue regard for the rightful independence of state governments." *Healy v. Ratta*, 292 U.S. 263, 270 (1934); *see Shamrock Oil & Gas Corp. v. Sheets*, 313 U.S. 100, 108 (1941).

The well-pleaded complaint rule long has served as "the basic principle marking the boundaries of the federal question jurisdiction of the federal district courts." *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987). Because respondents' complaint raises claims only under Illinois law, HCSC invokes two narrow exceptions to the well-pleaded complaint rule – one judicially created (complete preemption), the other statutory (the federal officer removal statute). Neither exception supports removal in this case.

I. COMPLETE PREEMPTION DOES NOT PROVIDE A BASIS FOR REMOVAL JURISDICTION UNDER FEHBA

The general federal removal statute provides that "any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants" to federal court. 28 U.S.C. § 1441(a).

In certain exceptional circumstances, the doctrine of complete preemption works to transform a state cause of action into a federal cause of action over which a district court has "original jurisdiction," thereby supporting removal under § 1441(a). Complete preemption does not supply a basis for jurisdiction here, however, because FEHBA does not create a cause of action over which federal courts have original jurisdiction. Moreover, the administrative remedy created by OPM is not exclusive.

A. Complete Preemption Does Not Apply Because FEHBA Does Not Create A Judicial Cause Of Action Over Which Federal Courts Have Original Jurisdiction

1. *The preempting statute must contain a judicial cause of action*

This Court recently confirmed that complete preemption rests on a federal statutory cause of action created by Congress. In *Beneficial National Bank v. Anderson*, 539 U.S. 1 (2003), the Court explained that complete preemption may supply a basis for removal jurisdiction where "the federal statute[] at issue provide[s] the exclusive cause of action for the claim asserted and also set[s] forth procedures and remedies governing that cause of action." *Id.* at 8. This Court has applied that principle to find complete preemption in only three statutory contexts.

First, the Court has held that § 301 of the Labor Management Relations Act, 1947 ("LMRA") completely preempts certain state-law claims. The LMRA creates a cause of action enforceable in federal district court for violations of collective bargaining agreements. *See* 29 U.S.C. § 185(a) ("[s]uits for violation of contracts between an employer and a labor organization representing employees . . . , or between

any such labor organizations, may be brought in any district court of the United States having jurisdiction of the parties"). That cause of action, in turn, supports complete preemption.

In *Avco Corp. v. Aero Lodge No. 735, International Association of Machinists*, 390 U.S. 557 (1968), this Court held that a state-court action to enjoin a union and its members from striking gave rise to removal jurisdiction. The Court explained that the dispute centered on a "'no-strike' clause in the collective bargaining agreement" and that § 301 created a federal cause of action governing violations of such agreements. *Id.* at 558, 559-60. Accordingly, "the claim under th[e] collective bargaining agreement [was] one arising under the 'laws of the United States' within the meaning of the removal statute." *Id.* at 560. *Avco* "stands for the proposition that if a federal cause of action completely preempts a state cause of action any complaint that comes within the scope of the federal cause of action necessarily 'arises under' federal law." *Franchise Tax Bd. v. Construction Laborers Vacation Trust for Southern California*, 463 U.S. 1, 23-24 (1983).

Second, this Court has held § 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA") completely preempts certain state-law claims. Like LMRA § 301(a), ERISA § 502(a) creates a cause of action over which federal courts have original jurisdiction for the recovery of benefits under ERISA plans. *See* 29 U.S.C. § 1132(a)(1)(B) ("[a] civil action may be brought . . . by a participant or beneficiary," among other things, "to recover benefits due to him under the terms of his plan").

This Court made clear that the § 502(a) cause of action, not ERISA's preemption provision, underlies

the complete preemption analysis. In *Taylor*, the Court addressed whether "state common law claims are not only pre-empted by ERISA," but also completely preempted by "ERISA's civil enforcement provision, § 502(a)(1)(B)." 481 U.S. at 60. The Court concluded that they were: the suit "f[ell] directly under § 502(a)(1)(B) of ERISA, which provides an exclusive federal cause of action for resolution of such disputes." *Id.* at 62-63. Based on the "unique preemptive force of ERISA" as well as ERISA's legislative history, the Court discerned a "clear [congressional] intention to make § 502(a)(1)(B) suits . . . federal questions for the purposes of federal court jurisdiction in like manner as § 301 of the LMRA." *Id.* at 65, 66. *See also Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) ("[t]his integrated enforcement mechanism, ERISA, § 502(a), 29 U.S.C. § 1132(a), is a distinctive feature of ERISA"); *id.* at 209.

Third, this Court has held that § 86 of the National Bank Act ("NBA") completely preempts state-law usury claims. *See Beneficial Nat'l Bank*, 539 U.S. at 3-4. Section 86 creates a cause of action for usury claims over which federal district courts have original jurisdiction.[5] As with LMRA § 301 and ERISA § 502(a), the exclusive scope of NBA § 86 triggers complete preemption. The Court crystallized the central role played by the cause of action, noting "the proper inquiry focuses on whether Congress intended the federal cause of action to be exclusive." *Id.* at 9 n.5. The Court then held – relying primarily on precedent interpreting the NBA as wholly displacing

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[5] *See* 12 U.S.C. § 86 (person who paid greater interest "may recover back, in an action in the nature of an action of debt, twice the amount of the interest thus paid from the association taking or receiving the same").

state law – that Congress "intended § 86 to provide the exclusive cause of action for usury claims against national banks." *Id.* at 9.

In sum, an essential element of complete preemption is that "the federal statute[] at issue provide[] the exclusive cause of action for the claim asserted" as a substitute for the displaced state cause of action. *Id.* at 8.

2. *FEHBA does not create a judicial cause of action*

FEHBA cannot completely preempt respondents' claims because, unlike the LMRA, ERISA, and the NBA, FEHBA does not create a substitute cause of action over which federal courts have original jurisdiction.

a. It is undisputed that FEHBA does not create a cause of action. *See* Def.'s Mem. in Support of Its Motion To Dismiss Pls.' Am. Compl. 15 (Dec. 19, 2007) ("[T]here is no judicial cause of action that Plaintiffs can invoke in order to challenge allegedly wrongful Plan administration by HCSC."); Pet. Br. 18 ("The precise cause of action available in the suit to compel enrollment is a judicial review claim under the [Administrative Procedure Act ("APA")].").

Under *Beneficial National Bank*, *Avco*, and *Taylor*, that should end the jurisdictional inquiry. Because no substitute federal cause of action under FEHBA covers respondents' state-law claims, no available mechanism exists for transforming those claims into claims "arising under" federal law to support federal jurisdiction. *See, e.g.*, *Aetna Health*, 542 U.S. at 209 ("Since LMRA § 301 converts state causes of action into federal ones for purposes of . . . removal, so too does ERISA § 502(a)(1)(B)."). (citation omitted).

b. Section 8912 does not alter that analysis. That provision confers jurisdiction on "district courts of the United States . . . concurrent with the United States Court of Federal Claims" over "a civil action or claim against the United States founded on [FEHBA]." 5 U.S.C. § 8912. In addition to the dispositive fact that § 8912 supplies jurisdiction only in actions "against the United States" – and this is not such a case (*see infra* pp. 29-30) – § 8912 does not create a cause of action. Instead, it fulfills the narrow "purpose" – "evident from its reference to the Court of Federal Claims" – of "carv[ing] out an exception to the statutory rule that claims brought against the United States and exceeding $10,000 must originate in the Court of Federal Claims." *Empire*, 547 U.S. at 686. *Accord Sosa v. Alvarez-Machain*, 542 U.S. 692, 713-14 (2004) (Alien Tort Statute's jurisdiction provision was "simply . . . a jurisdictional grant," not "authority for the creation of a new cause of action").

Nor does this Court's discussion in *Taylor* of ERISA's jurisdictional provision, § 502(f), suggest that a jurisdictional provision alone can trigger complete preemption, as HCSC contends. *See* Pet. Br. 18, 21. Consistent with its unbroken line of complete preemption decisions, the *Taylor* Court stressed that the preemptive force of ERISA's cause of action – § 502(a)(1)(B) – drove the complete preemption analysis. *See* 481 U.S. at 60 ("[t]he question presented . . . is whether these state common law claims" are "displaced by . . . § 502(a)(1)(B)"); *id.* at 66. The Court viewed the jurisdictional provision in § 502(f) as simply verifying Congress's intent for § 502(a) to be so exclusive as to completely preempt state-law claims. *Id.* at 65. *Taylor* does not support the notion

that a stand-alone jurisdictional provision – such as § 8912 – is sufficient to compel complete preemption.

3. *This Court should not expand complete preemption to include statutes enforced through administrative remedies*

This Court has never held that a federal statute completely preempts a state-law cause of action absent a substitute federal-law cause of action over which federal courts have original jurisdiction. Thus, HCSC seeks to expand the complete preemption doctrine so that it applies whenever a statute authorizes administrative remedies subject to ultimate judicial review under the APA. *See* Pet. Br. 17-18. Such a substantial expansion is unwarranted.

a. First, the theoretical foundation of complete preemption will not support its expansion to encompass administrative remedies. Complete preemption rests on the fiction that, although a plaintiff has styled a claim as a state cause of action, no such cause of action exists because Congress has swept away all state substantive law and replaced it with an exclusive federal cause of action. Hence, the plaintiff really has pleaded a federal claim, and the doctrine accordingly substitutes a federal cause of action for the state cause of action. *See, e.g., Franchise Tax Bd.*, 463 U.S. at 26; *Aetna Health*, 542 U.S. at 209.

In light of that conceptual foundation, "a vital feature of complete preemption is the existence of a federal cause of action that replaces the preempted state cause of action"; "[w]here no discernible federal cause of action exists on a plaintiff's claim, there is no complete preemption." *King v. Marriott Int'l, Inc.*, 337 F.3d 421, 425 (4th Cir. 2003). When a statute (such as FEHBA) does not create a substitute cause

of action over which a federal *court* has original jurisdiction, complete preemption cannot apply. HCSC's proposed expansion of complete preemption, therefore, finds no support in the conceptual logic of the removal doctrine.

The courts of appeals concur. In *Sullivan v. American Airlines, Inc.*, 424 F.3d 267 (2d Cir. 2005), the Second Circuit held that the Railway Labor Act ("RLA") did not completely preempt a state-law defamation claim brought by union workers and employees against American Airlines. Relying on *Beneficial National Bank*, the court explained that complete preemption requires that a federal statute create a cause of action over which federal courts have "original federal jurisdiction." *Id.* at 276. The RLA, however, did not permit the dispute to "be filed in the first instance in federal court," but required that it be resolved first by administrative "boards established pursuant to the [RLA]." *Id.* Indeed, the court noted that the defendant (like HCSC here) had removed the case "for the sole purpose of asking that court to dismiss [the] claim on the basis that the federal court could not hear it." *Id.* In such circumstances, complete preemption cannot apply: "Because . . . disputes [subject to the RLA] cannot be brought in federal court in the first instance, federal courts may not take jurisdiction over them simply to dismiss them on the basis that they are defensively preempted and belong before arbitral panels." *Id.* at 278; *see also Moore-Thomas v. Alaska Airlines, Inc.*, 553 F.3d 1241, 1245-46 (9th Cir. 2009) (no complete preemption under RLA); *Lontz v. Tharp*, 413 F.3d 435, 442-43 (4th Cir. 2005) (no complete preemption under National Labor Relations Act because "Congress has not chosen to create a cause of action" over which

district courts have original jurisdiction; "Congress's allocation of authority to an agency and away from district courts defeats a complete preemption claim"); *Utley v. Varian Assocs., Inc.*, 811 F.2d 1279, 1287 (9th Cir. 1987) (administrative remedy cannot support complete preemption).[6]

b. Second, an expansion of complete preemption to include administrative remedies would countermand the principle that complete preemption is a narrow exception to the well-pleaded complaint rule. In *Taylor*, for example, this Court explained that it is "reluctant to find" complete preemption even in statutes creating a federal cause with "unique[ly] preemptive force." 481 U.S. at 65. And, in *Beneficial National Bank*, the Court emphasized the "general rule" that "a case will not be removable if the complaint does not affirmatively allege a federal claim" and that only the "preemptive force" of "unusually powerful" causes of action will trigger complete preemption. 539 U.S. at 7. Courts of appeals properly have interpreted that precedent to mean complete preemption is an "extreme and unusual outcome," *Fayard v. Northeast Vehicle Servs., LLC*, 533 F.3d 42, 49 (1st Cir. 2008), and that "exacting standards" must be satisfied to trigger it, *Lontz*, 413 F.3d at 441.

Unmooring the complete preemption doctrine from a requirement that a statute create a cause of action over which federal courts have original jurisdiction

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[6] The Solicitor General previously has embraced that rationale: "Congress sometimes occupies a field in order to provide a comprehensive administrative remedy. . . . In those circumstances, there is no removal under complete preemption principles because there is no substitute federal cause of action that gives the federal district courts original jurisdiction." Brief for the United States as Amicus Curiae Supporting Petitioners at 19 n.3, *Beneficial Nat'l Bank*, *supra* (No. 02-306).

would substantially expand the doctrine and thus federal jurisdiction. As HCSC explains, "[t]he APA presumptively applies whenever an aggrieved party challenges final federal agency action." Pet. Br. 18 (citing *Japan Whaling Ass'n v. American Cetacean Soc'y*, 478 U.S. 221, 230 (1986)). Under HCSC's theory, *any* federal statute that creates administrative remedies or *any* statute under which an agency has interpreted statutory silence to allow the creation of administrative remedies through regulation would become a candidate for complete preemption. HCSC offers no limiting principle to such a sweeping expansion of the doctrine. In any event, HCSC's assertion of complete preemption here cannot be squared with this Court's admonition that the doctrine should be an extreme and unusual basis for federal jurisdiction.

Furthermore, such an expansion of complete preemption would upset the jurisdictional division between state and federal courts. It has long been the rule that a plaintiff is the "master of [his or her] claim; he or she may avoid federal jurisdiction by exclusive reliance on state law." *Caterpillar Inc. v. Williams*, 482 U.S. 386, 392 (1987); *see The Fair v. Kohler Die & Specialty Co.*, 228 U.S. 22, 25 (1913) (Holmes, J.). Consistent with the "paramount policies embodied in the well-pleaded complaint rule," this Court has held that a "defendant cannot, merely by injecting a federal question into an action that asserts what is plainly a state-law claim, transform the action into one arising under federal law, thereby selecting the forum in which the claim shall be litigated." *Caterpillar*, 482 U.S. at 399 (emphasis omitted). Because such a rule would make the plaintiff "master of nothing[,] Congress has long since decided

that federal defenses do not provide a basis for removal." *Id.*

Indeed, HCSC's suggested expansion of the doctrine would disregard the principle that federal jurisdiction must be narrowly confined out of "[d]ue regard for the rightful independence of state governments." *Healy*, 292 U.S. at 270; *see Lontz*, 413 F.3d at 441 (because of "significant federalism concerns," "[t]he presumption . . . is against finding complete preemption"). Adherence to that principle is particularly appropriate here: HCSC has offered no theory (nor could it) for why state courts are not competent to enforce any exhaustion rules under FEHBA. This Court has "consistently held that state courts have inherent authority, and are thus presumptively competent, to adjudicate claims arising under the laws of the United States." *Tafflin v. Levitt*, 493 U.S. 455, 458-59 (1990); *see Lontz*, 413 F.3d at 442. No justification exists for ascribing to Congress an intent to burden federal courts with the task of superintending all administrative exhaustion rules through a *sub silentio* expansion of federal removal jurisdiction. *See, e.g., Will v. Michigan Dep't of State Police*, 491 U.S. 58, 65 (1989); *United States v. Bass*, 404 U.S. 336, 349-50 (1971).

B. FEHBA's Non-Exclusive Remedial Scheme Undermines Any Complete Preemption Claim

1. Even if FEHBA's administrative remedy were a potential candidate for complete preemption, that remedy is not "exclusive" and therefore cannot support complete preemption. *Beneficial Nat'l Bank*, 539 U.S. at 8. HCSC faces the high standard of establishing that FEHBA has "extraordinary preemptive power." *Aetna Health*, 542 U.S. at 209

(internal quotations omitted). FEHBA does not come close to satisfying that standard: no provision in FEHBA expressly creates administrative remedies; no provision purports to make any remedies created exclusive; and no provision extinguishes all state substantive and remedial law arguably touching upon federal employee health benefits issues.

FEHBA does contain a preemption provision and a jurisdictional provision. But those provisions – far from supporting a finding of exclusivity – make clear that FEHBA is *not* a comprehensive or exclusive regime of rights and remedies for all issues arguably relating to federal employee health benefits.

a. FEHBA's preemption provision is exceptionally narrow. It provides that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits . . . shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1). Unlike ERISA's preemption provision, § 8902(m)(1)'s "text does not purport to render inoperative *any and all* state laws that in some way bear on federal employee-benefit plans." *Empire*, 547 U.S. at 698.

Beyond that, § 8902(m)(1) – again unlike the LMRA's and ERISA's preemption provisions – purports to make *contract terms* between OPM and FEHBA carriers preemptive. The provision "declares no federal *law* preemptive." *Id.* (emphasis added). Referring to § 8902(m)(1) as a "choice-of-law prescription," this Court concluded that "[a] prescription of that unusual order warrants cautious interpretation." *Id.* at 697.

Notwithstanding HCSC's assertions to the contrary (at 27-29), the drafting history confirms the wisdom

of this Court's cautious approach. Section 8902(m)(1) was initially added to FEHBA in 1978, *see* Pub. L. No. 95-368, § 1, 92 Stat. 606, in response to an increase in state regulation of the insurance industry. In particular, during the early 1970s, "more and more States . . . legislated the kinds of benefits and medical practitioners that carriers doing business in these States must cover." H.R. Rep. No. 95-282, at 6 (1977) (reproducing Letter from Alan K. Campbell, Chairman of the United States Civil Service Commission, to Robert N.C. Nix, Chairman of the Committee on Post Office and Civil Service). Some of those requirements conflicted with the coverage and benefits provisions of the annual FEHBA contracts. Those conflicts caused confusion among carriers and threatened the uniformity of the federal health insurance program. As the Committee noted, "the Indemnity Benefit Plan . . . pays for chiropractic services in Nevada, as required by State law, but does not pay for such services in any other State." *Id.* at 3. And, because premiums are established uniformly at the national level, the proliferation of different state coverage mandates resulted "in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other states." *Id.* at 4. Congress responded by enacting a particularized solution – a preemption provision authorizing the coverage and benefits terms of the nationwide FEHBA contract to preempt state laws and regulations that mandated conflicting coverage and benefits terms. The original preemption provision read:

> The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with

> respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans *to the extent that such law or regulation is inconsistent with such contractual provisions.*

5 U.S.C. § 8902(m)(1) (1982) (emphasis added).

The 1998 amendment to § 8902(m)(1) eliminated the "conflict" portion of the preemption provision, but did not change its narrow focus on state laws and regulations relating to coverage and benefits. *See Empire*, 547 U.S. at 683 (preemption provision "displace[s] state law on issues relating to 'coverage or benefits'"). That amendment expanded the preemptive reach of contract provisions to displace state laws and regulations about coverage and benefits that did not expressly conflict with those nationwide terms as well as those that were in direct conflict. *See* H.R. Rep. No. 105-374, at 16 (1997). Thus, the provision's text and drafting history clarify that Congress did not intend FEHBA to "cover the entire subject" of federal employee health insurance such "that State law would have no bearing whatever." *Beneficial Nat'l Bank*, 539 U.S. at 10 (internal quotations omitted).

That conclusion also follows from this Court's presumption that Congress does not intend state substantive or remedial law to be rendered inoperative by federal law "unless that was the clear and manifest purpose of Congress." *Altria Group, Inc. v. Good*, 129 S. Ct. 538, 543 (2008) (internal quotations omitted). Therefore, "when the text of a pre-emption clause is susceptible of more than one plausible reading, courts ordinarily 'accept the reading that disfavors pre-emption.'" *Id.* (quoting *Bates v. Dow Agro-*

Sciences LLC, 544 U.S. 431, 449 (2005)). That presumption against preemption compels construing any ambiguity in § 8902(m)(1) so as not to preempt all state law arguably touching upon issues of federal employee health benefits. *See Empire*, 547 U.S. at 698 ("[i]f Congress intends a preemption instruction completely to displace ordinarily applicable state law, . . . it may be expected to make that atypical intention clear," and § 8902(m)(1) "is not sufficiently broad" to satisfy that standard).

Furthermore, the limited preemptive scope of § 8902(m)(1) follows from the fact that the statute makes contracts, not "federal law," preemptive. *Empire*, 547 U.S. at 698. As explained, that anomaly led this Court to conclude that, at most, a "cautious" and "modest" reading of § 8902(m)(1) is appropriate. *Id.* at 697-98. Indeed, the provision itself arguably has no preemptive effect at all in this case. The Supremacy Clause of the United States Constitution makes "Laws of the United States . . . supreme." U.S. Const. art. VI, cl. 2. A contract between OPM and FEHBA carriers, however, is not a "Law[] of the United States." *See American Airlines, Inc. v. Wolens*, 513 U.S. 219, 241 (1995) (O'Connor, J., concurring in the judgment in part and dissenting in part) ("the terms of private contracts are not 'laws'"). Accordingly, a serious constitutional question exists whether § 8902(m)(1) may be given *any* substantive preemptive effect. At the least, this Court should construe the preemption provision narrowly to avoid such constitutional concerns. *See Arizonans for Official English v. Arizona*, 520 U.S. 43, 78 (1997) ("Federal courts, when confronting a challenge to the constitutionality of a federal statute, follow a 'cardinal principle': They 'will first ascertain whether a

construction . . . is fairly possible' that will contain the statute within constitutional bounds.") (quoting *Ashwander v. Tennessee Valley Auth.*, 297 U.S. 288, 348 (1936) (Brandeis, J., concurring)). FEHBA's preemption provision, narrowly read, is insufficiently "powerful" to trigger complete preemption, particularly given that the subject matter of respondents' claims does not conflict with any contract terms to which HCSC agreed. *Taylor*, 481 U.S. at 64.

b. FEHBA's jurisdictional provision – § 8912 – also is limited and forecloses a conclusion that Congress intended any remedies under FEHBA to be exclusive. Section 8912 supplies "original jurisdiction, concurrent with the United States Court of Federal Claims, of a civil action or claim against the United States." 5 U.S.C. § 8912. That grant of jurisdiction, of course, is not exclusive: "It is black letter law that the mere grant of jurisdiction to a federal court does not operate to oust a state court from concurrent jurisdiction over the cause of action." *Tafflin*, 493 U.S. at 460-61 (internal quotations and alterations omitted). Indeed, this Court has held that § 8902(m)(1) serves only the narrow "purpose" of "carv[ing] out an exception to the statutory rule that claims brought against the United States and exceeding $10,000 must originate in the Court of Federal Claims." *Empire*, 547 U.S. at 686.

More fundamentally, FEHBA's jurisdictional provision – unlike the jurisdictional provisions in ERISA and the LMRA – applies only in the specific context of lawsuits brought "against the United States." 5 U.S.C. § 8912; *cf.* 29 U.S.C. §§ 185(a) (LMRA), 1132(f) (ERISA).

In *Finley*, this Court interpreted similar language in the Federal Tort Claims Act, which "confers juris-

diction over 'civil actions on claims against the United States.'" 490 U.S. at 552 (quoting 28 U.S.C. § 1346(b)(1)). The Court "conclud[ed] that 'against the United States' means against the United States and no one else" and thus that "[t]he statute . . . defines jurisdiction in a manner that does not reach defendants other than the United States." *Id.* at 552-53. The limited reach of FEHBA's jurisdictional provision, therefore, further shows that Congress did not intend FEHBA to create a comprehensive regime replacing all state law relating to federal employee health benefits. Indeed, in this case that jurisdictional limitation is crucial: respondents' complaint names HCSC – not the United States – as a defendant. Section 8912 therefore does not support HCSC's contention that respondents' claims are completely preempted.

2. Absent express textual or structural evidence that any remedies created under FEHBA are exclusive, and in the face of preemption and jurisdictional provisions that affirmatively foreclose any such conclusion, HCSC is left to cobble together a claim to exclusivity from several sources, none of which achieves HCSC's objective.

a. HCSC's principal argument for exclusivity is that OPM has promulgated "detailed regulations, including the administrative remedies for enrollment and benefits grievances." Pet. Br. 23-24. HCSC cites no OPM regulation making those remedies exclusive or preemptive of state law, however. Rather, it asserts that, because these remedies exist, "it would make no sense to deem the remedial regime anything but exclusive." *Id.* at 25. That argument has no merit.

First, complete preemption is a jurisdictional doctrine, and agencies are not free to expand or confine federal court jurisdiction through regulation. Although "Congress [may have] clearly envisioned, indeed expressly mandated, a role" for OPM "in administering the statute" by delegating authority to OPM to make rules, "[t]his delegation . . . does not empower" OPM "to regulate the scope of the judicial power vested by the statute." *Adams Fruit Co. v. Barrett*, 494 U.S. 638, 650 (1990); *see AmSouth Bank v. Dale*, 386 F.3d 763, 777 (6th Cir. 2004) ("While the agency can create federal law, it cannot expand federal jurisdiction."). Courts of appeals have correctly interpreted those principles to mean that exclusivity giving rise to complete preemption must arise in "the enabling statute" and not in agency regulations. *AmSouth*, 386 F.3d at 776-77. Accordingly, this Court has said that complete preemption applies only "[w]hen the *federal statute* completely pre-empts the state-law cause of action" and only when "*Congress* [has] intended the federal cause of action to be exclusive." *Beneficial Nat'l Bank*, 539 U.S. at 8-9 n.5 (emphases added); *see Taylor*, 481 U.S. at 66.

Second, even if OPM could create an exclusive remedial regime that affected the removal jurisdiction of federal courts, it has not done so here. OPM's regulations are silent regarding the possibility of parallel state substantive and/or remedial law supplementing the administrative processes created. The strong presumption against construing federal law as displacing state law absent an express statement of such intent, therefore, forecloses interpreting OPM's regulations as exclusive. *See Altria*, 129 S. Ct. at 543; *supra* pp. 27-28.

Third, HCSC incorrectly asserts that the mere existence of administrative processes for benefits and enrollment claims means that all state substantive and remedial laws arguably relating to federal employee health benefits are extinguished. Merely because administrative remedies ensure that employees have timely access to benefits and enrollment does not suggest any intent to displace longstanding state-law causes of action that serve different ends. *See Sprietsma v. Mercury Marine*, 537 U.S. 51, 64 (2002) ("It would have been perfectly rational for Congress not to pre-empt common-law claims, which – unlike most administrative and legislative regulations – necessarily perform an important remedial role in compensating accident victims."). OPM's rules, for example, limit the remedies available to an "order directing OPM to require the carrier to pay the amount of benefits in dispute." 5 C.F.R. § 890.107(c). In addition, only "covered individual[s]" may file a claim for benefits, *id.* § 890.105(a)(1) – an exclusion that means, for example, that the administrative process is unavailable to Mr. Nash notwithstanding the direct harm inflicted upon him by HCSC's bad-faith conduct. By the time HCSC filed its notice of removal, it had already mooted respondents' claims related to benefits and enrollment decisions by reinstating Michael's coverage. Respondents' remaining claims seek to hold HCSC liable under well-established state-law claims of bad faith. Nothing in OPM's regulations evidences any intention of displacing such causes of action.

HCSC's reading of OPM's rules, therefore, requires ascribing to OPM the intent to extinguish *all* state substantive and remedial law protecting *all* persons (whether a covered individual or otherwise) from

bad-faith conduct by insurers and to eliminate covered parties' ability to recover anything more than "the amount of benefits in dispute" no matter the level of harm inflicted upon a party by a FEHBA carrier's wrongful conduct. Even if OPM could be given such sweeping authority to displace state law, this Court should decline to infer its exercise from mere silence. *See Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 251 (1984) ("It is difficult to believe that Congress would, without comment, remove all means of judicial recourse for those injured by illegal conduct.").

b. HCSC further argues that "[t]he Court's decision in *Empire* supports the exclusivity of the federal remedies for FEHBA enrollment and benefits grievances." Pet. Br. 30. HCSC asserts that the Court "anticipated" in *Empire* "that FEHBA coverage and benefits controversies . . . inevitably 'will land' in federal court." *Id.* at 31. HCSC's reading of *Empire* is unpersuasive.

In *Empire*, this Court addressed whether a claim brought by a FEHBA carrier in federal court raised a federal question under 28 U.S.C. § 1331. *See* 547 U.S. at 683. *Empire* had nothing to do with removal jurisdiction (or, necessarily, complete preemption). The Court's statement that federal courthouses would be open to benefits cases simply reflects that judicial review is available of OPM benefits determinations under the APA, an observation that says nothing about removal jurisdiction. *See Landgraf v. USI Film Prods.*, 511 U.S. 244, 265 (1994) (it is a "canon of unquestionable vitality . . . 'that general expressions, in every opinion, are to be taken in connection with the case in which those expressions are used'") (quoting *Cohens v. Virginia*, 19 U.S. (6

Wheat.) 264, 399 (1821)).[7] Accordingly, nothing in *Empire* undermines the conclusion that FEHBA does not completely preempt respondents' claims.

II. THE FEDERAL OFFICER REMOVAL STATUTE DOES NOT SUPPORT REMOVAL

HCSC also has not established a basis for removal under the federal officer removal statute. That statute provides, in relevant part, that "[a] civil action . . . commenced in a State court against . . . [t]he United States or any agency thereof or any officer (or any person acting under that officer) of the United States or of any agency thereof, sued in an official or individual capacity for any act under color of such office," may be removed to federal court. 28 U.S.C. § 1442(a)(1). To satisfy that provision, a private party has the burden of establishing three elements.

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[7] HCSC also argues (at 31) that *Empire* supports the conclusion that complete preemption applies inasmuch as it recognizes that "[t]he case for exclusivity and complete preemption is stronger if federal law provides the substantive rules of decision over the controversy." According to HCSC, FEHBA benefits and enrollments disputes are governed by "federal common law," strengthening the case for removal jurisdiction. *Id.* at 32. That argument has no relevance in the context of removal jurisdiction. As this Court explained in *Empire*, the issue in *Clearfield Trust Co. v. United States*, 318 U.S. 363 (1943), was not jurisdictional but rather "a vertical choice-of-law issue" of whether state law or federal common law would govern a claim. 547 U.S. at 691. In cases brought in federal court under 28 U.S.C. § 1331, as was *Empire*, this choice-of-law issue may have jurisdictional significance: if a claim "arises under" federal common law, then it satisfies § 1331. This, however, is not a case involving the interpretation of § 1331; the question here is whether a *state-law* cause of action brought in state court is removable to federal court under the complete preemption doctrine and § 1441(a). *Empire*'s discussion of *Clearfield* does not concern that question.

First, a private party must be a person "acting under" a federal officer. *See Watson*, 551 U.S. at 151-53. Second, such a party must establish that the suit is for an "act under color of such office," 28 U.S.C. § 1442(a)(1), by showing a "'causal connection' between the charged conduct and asserted official authority." *Jefferson County v. Acker*, 527 U.S. 423, 431 (1999) (quoting *Willingham v. Morgan*, 395 U.S. 402, 409 (1969)). Third, the defendant must assert a colorable federal defense. *See Mesa v. California*, 489 U.S. 121, 129 (1989). HCSC may not avail itself of the "exceptional" remedy of federal officer removal, *Maryland v. Soper*, 270 U.S. 9, 35 (1926), because it cannot meet two of those three elements. Part II.A addresses the "color of . . . office" element, because the court below remanded for fact-finding with respect to that element. Part II.B then explains why HCSC fails to meet the "acting under" element.

A. HCSC Was Not Sued For Acts "Under Color Of . . . Office"

1. HCSC is not entitled to federal officer removal because respondents' complaint does not seek to hold it liable "*for* a[n] act under color of office." *Acker*, 527 U.S. at 431 (internal quotations omitted). The court below properly remanded because of substantial doubts HCSC can meet that requirement as a factual matter.

This Court's decision in *Soper* – which involved a statutory antecedent to the current federal officer removal statute – shows how courts should analyze disputed facts in this context. There, the Court concluded that "the averments of the amended petition" were not "sufficiently informing and specific to make a case for removal." 270 U.S. at 34. Although the removing defendants (four federal officers and a chauffeur) averred that all of the alleged acts would

have occurred "at a time when [defendants] were engaged in the discharge of their official duties as Federal Prohibition Officers," the Court found those allegations of official-capacity conduct insufficient. *Id.* at 34-35 (internal quotations omitted). Averments suggesting that the wrongful acts occurred "at a time when [defendants] were engaged in performing their official duties" did not "negative the possibility that they were doing other acts than official acts at the time . . . or make it clear and specific that whatever was done by them leading to the prosecution was done under color of their federal official duty." *Id.* at 35.

Colorado v. Symes, 286 U.S. 510 (1932), confirms the Seventh Circuit's approach in remanding for an evidentiary hearing. A federal prohibition officer charged with murder in Colorado state court, Symes sought to remove the case to federal court. To support his motion to remove, Symes filed an affidavit claiming that the victim was killed while resisting arrest. *Id.* at 520. In rejecting the averments as "vague, indefinite and uncertain," *id.* at 520-21, the Court held that the district court had discretion to permit introduction of additional evidence to establish jurisdictional facts or to remand the case to state court, *id.* at 521.

The factual record here, like those in *Soper* and *Symes*, is insufficient to support removal. Respondents have alleged that HCSC engaged in bad-faith conduct not compelled by federal law in, among other things, changing Ms. Pollitt's enrollment status retroactively and seeking recoupment of past payments made to medical providers. *See* JA123-30; Pet. App. 3a ("Pollitt maintains that HCSC acted unilaterally in concluding that her coverage was for self only

rather than self and family"). Although HCSC has submitted an affidavit asserting that it made the enrollment change at the behest of DOL, that assertion is contradicted by the allegations of the complaint, *see* Pet. App. 3a ("the parties are at odds about what (if any) directions [DOL] issued to HCSC"), and the documentary evidence, *see supra* p. 4 n.4. Furthermore, respondents have had no opportunity to test HCSC's assertion through even limited discovery, nor has a court held an evidentiary hearing to test the limited evidence submitted to date. The assertion that DOL instructed HCSC to change Ms. Pollitt's status is the very type of conclusory factual averment that should be assessed through an evidentiary hearing and/or discovery. That allegation, like the averments in *Soper*, is not "sufficiently informing and specific to make a case for removal." *Soper*, 270 U.S. at 34; *see Symes*, 286 U.S. at 521.[8]

2. In response, HCSC erroneously contends that this Court's precedent establishes that – for jurisdictional purposes – the courts below were obliged to credit HCSC's naked assertions that the conduct forming the basis for respondents' complaint had a causal connection to official authority. *See* Pet. Br. 38, 46-48, 55-56. HCSC points to *Davis v. South Carolina*, 107 U.S. 597 (1883), for example, for the

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[8] There is nothing exceptional about the decision to require fact-finding by a district court with respect to jurisdictional facts underlying removal jurisdiction even in civil cases. *See* 14C Wright § 3739 ("When it plainly appears from the notice of removal that there is a basis for removal, a factual hearing is unnecessary. . . . [H]owever, federal courts often do conduct hearings on motions to remand, particularly when factual issues are present, and they permit the parties to introduce various types of material.").

proposition that there is no requirement that conduct alleged in a complaint have resulted from "specific federal directives." Pet. Br. 55. But, as the Court noted in *Watson*, the removing defendant in *Davis* – a U.S. Army corporal – unquestionably was acting in an official capacity when he "shot the [escaping] suspect" during a raid in which "several . . . soldiers helped a federal revenue officer try to arrest a distiller for violating the internal-revenue laws." 551 U.S. at 149. *Davis*, unlike this case, did not concern whether the defendant was assisting a federal officer in performing an official function.

The requirement that a removing party establish a factual basis for removal also is consistent with *Willingham* and *Acker*, contrary to HCSC's assertion. *See* Pet. Br. 45-48. *Willingham* involved state-law claims against the warden and chief medical officer of a federal penitentiary. *See* 395 U.S. at 403. This Court addressed whether "the record in [the] case . . . support[ed] a *finding* that respondent's suit grows out of conduct under color of office." *Id.* at 407 (emphasis added). The Court found that requisite met because the defendants had averred that their only contacts with the plaintiff arose "in performance of . . . official duties" at the federal penitentiary. *Id.* at 407-08. And, because the plaintiff had not "den[ied]" those "statements in his responsive affidavit," the Court deemed the record sufficient to show that the federal officers' "relationship to [the plaintiff] derived solely from their official duties." *Id.* at 408-09. Setting aside that *Willingham* was a case involving *bona fide* federal officers rather than private parties, *Willingham* is of no help to HCSC: this Court reviewed the entire record to determine whether the facts supported removal. *Willingham*

thus supports the Seventh Circuit's decision to require basic fact-finding with respect to a disputed jurisdictional fact.

Acker also is inapposite. That case, too, involved actual federal officers – federal judges who argued that tax collection suits by a county violated the intergovernmental tax immunity doctrine. 527 U.S. at 429. The heart of the removal dispute was purely legal: whether the tax was aimed at the judges for engaging in their "occupation" or whether the tax was aimed at them in their "personal[]" capacity. *Id.* at 432. In that circumstance, for the Court "[t]o choose between those readings of the [tax ordinance]" would be "to decide the merits of th[e] case." *Id.* To avoid that anomalous result, the Court "credit[ed] the judges' theory of the case for purposes of . . . [the] jurisdictional inquiry." *Id.* Here, HCSC, unlike the federal officers in *Acker*, is a private party. Moreover, the dispute here, unlike in *Acker*, is a question of fact, not of law, which can be decided independent of the merits defenses proffered by HCSC. *Acker* therefore does not compel the counterintuitive result that federal jurisdiction exists based solely on HCSC's untested claim that it was acting on DOL's instructions.[9]

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[9] Furthermore, even if *bona fide* federal officers enjoy a relaxed threshold for demonstrating that challenged conduct is causally connected to the officer's authority, a private party *not* cloaked with the imprimatur of federal authority by virtue of holding federal office stands in a very different position for which a presumption of causation is inappropriate. *See, e.g., In re Methyl Tertiary Butyl Ether ("MTBE") Prods. Liab. Litig.*, 488 F.3d 112, 124-25 (2d Cir. 2007); *Orthopedic Specialists of New Jersey PA v. Horizon Blue Cross/Blue Shield of New Jersey*, 518 F. Supp. 2d 128, 133 (D.N.J. 2007).

Unlike *Willingham* and *Acker*, in which defendants claimed official immunity as their colorable federal defense, here HCSC (a private entity) raised a preemption defense in the district court, and adds a sovereign immunity defense for the first time in this Court. Whereas resolving official immunity defenses in federal court is a core justification for the federal officer removal statute, state courts are presumed competent to resolve other federal issues. *See, e.g.*, *International Primate Prot. League v. Administrators of Tulane Educ. Fund*, 500 U.S. 72, 85 (1991) ("The determination of an agency's immunity . . . [is] sufficiently straightforward that a state court, even if hostile to the federal interest, would be unlikely to disregard the law."). In addition, the preemption and sovereign immunity defenses are entirely distinct from HCSC's claim to be acting under a federal officer. FEHBA's preemption inquiry turns on the scope of § 8902(m)(1), not on whether HCSC acted pursuant to DOL's direction. The sovereign immunity defense requires HCSC to prove that any recovery against a FEHB carrier for state-law claims sounding in bad faith would impact the federal treasury. Thus, by remanding to the district court for resolution of the jurisdictional facts, the court below did not require HCSC to prevail on the merits to justify removal. Accordingly, compelling HCSC to substantiate its claim to have acted under color of office will serve, not frustrate, the purposes of the federal officer removal statute.

Here, HCSC stands in a different position from the defendants in *Willingham* and *Acker* based, in part, on assertions of immunity. HCSC has no plausible claim to official immunity. The "color of law" requirement of 42 U.S.C. § 1983 is instructive. In

American Manufacturers Mutual Insurance Co. v. Sullivan, 526 U.S. 40 (1999), this Court held that "the under-color-of-state-law element of § 1983 excludes from its reach merely private conduct." *Id.* at 50 (internal quotations omitted). To act under "color of law" requires that a private party have "exercis[ed] power 'possessed by virtue of . . . law and made possible only because the [party] is clothed with the authority of . . . law.'" *Polk County v. Dodson*, 454 U.S. 312, 317-18 (1981) (quoting *United States v. Classic*, 313 U.S. 299, 326 (1941)). Because HCSC has no claim to be clothed with the authority of law, *see Rendell-Baker v. Kohn*, 457 U.S. 830, 840-42 (1982), it has no claim to be acting "under color of . . . office" here.

B. HCSC Was Not "Acting Under" A Federal Officer

If the Court concludes that fact-finding is appropriate with respect to the "color of . . . office" requirement, it need not address whether HCSC is a person "acting under" a federal officer. That question can be addressed (if necessary) by the lower courts on remand. If the Court reaches this question, however, it should hold that HCSC has not carried its burden of establishing that, as a private, commercial health insurer, it is "acting under" a federal officer. Although "the words 'acting under' are broad," they are not "limitless," and appropriate limits derive from the "language, context, history, and purposes" of the statute. *Watson*, 551 U.S. at 147. HCSC was not acting under a federal officer because it was neither "help[ing] officers fulfill [a] basic governmental task[]," *id.* at 153, nor in a relationship with an officer of "subjection, guidance, or control," *id.* at 151 (internal quotations omitted).

1. *HCSC was not assisting a federal officer in performing a sovereign, governmental function*

The federal officer removal statute does not provide a federal forum for resolving every action filed in state court against private contractors supplying the federal government with ordinary goods and services in the commercial marketplace. Instead, the text, structure, history, and purposes of the statute establish that private contractors are entitled to removal – if at all[10] – only insofar as they are acting on dele-

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[10] Although several lower courts have determined that Congress intended to include corporations when it authorized removal for a "person" acting under a federal officer in § 1442, *see, e.g., Isaacson v. Dow Chem. Co.*, 517 F.3d 129, 135-36 (2d Cir. 2008), this Court has not resolved the issue. Nor is it clear that Congress so intended. Although the Dictionary Act requires courts to presume that the legislative use of the word "person" includes corporations "unless the context indicates otherwise," 1 U.S.C. § 1, the context here does indicate otherwise. First, the version of the Dictionary Act in force when Congress used the word "person" in the federal officer removal statute said only that "the word 'person' may extend and be applied to . . . corporations." *Krangel v. Crown*, 791 F. Supp. 1436, 1439 (S.D. Cal. 1992). The presumption in the Act concerning Congress's intent has become more powerful over time, but Congress has not expressed any intent regarding the meaning of the word "person" in the federal officer removal statute since 1874. *Id.* at 1439-40. In fact, when Congress amended the statute in response to this Court's holding that the word "person" did not encompass federal agencies, it left in place the statutory protection for persons and officers and added federal agencies as a separate category of protected entity. Moreover, the history of the statute reveals a profound concern for the protection of vulnerable *individual* officers and employees of the federal government from prosecutions and lawsuits in unsympathetic state courts. *See Willingham*, 395 U.S. at 405-06; *Mesa*, 489 U.S. at 125 29; *International Primate Prot. League*, 500 U.S. at 85-86. That concern does not readily translate to corporations.

gated authority or directly assisting federal officers in fulfilling core governmental functions. HCSC did not act in those ways here.

a. Section 1442(a)(1) requires the defendant to be acting on delegated authority or assisting an officer in carrying out a sovereign, governmental function

Section 1442(a)(1)'s text and structure evince Congress's intent to extend the benefit of removal to private parties only insofar as those parties stand in the shoes of or assist the federal government in carrying out sovereign, governmental functions. As this Court explained in *Watson*, a contractor might be said to be "acting under" a federal officer when it "helps [the] officer[] fulfill . . . basic governmental tasks." 551 U.S. at 153. Giving effect to that limiting principle is crucial: otherwise, all private parties that provide services to the government may claim an entitlement to removal when sued for conduct arguably related to those services.

The text adjoining the "acting under" clause bolsters the conclusion that a contractor must have some claim to be acting on official authority or assisting in the performance of a sovereign function. The "acting under" clause is tied closely to the "color of office" element, requiring "a causal connection between the charged conduct and asserted *official authority*." *Acker*, 527 U.S. at 431 (internal quota-

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Moreover, the strong interests of the plaintiff in choosing a forum and of the States in adjudicating the rights and obligations of their citizens provide ample context for a conclusion that Congress did not intend the word "person" in the federal officer removal statute to include corporations such as HCSC. *See Krangel*, 791 F. Supp. at 1446.

tions omitted, emphasis added); *see also Willingham*, 395 U.S. at 406-07 (clause "cover[s] all cases where federal officers can raise a colorable defense arising out of their duty to enforce federal law"). Those decisions evidence Congress's understanding that removal is appropriate only in those circumstances involving the exercise of official authority or the performance of core sovereign functions, such as the enforcement of federal law. As explained above, HCSC has no such claim here.

b. HCSC does not act on delegated authority or assist the federal government in carrying out a sovereign, governmental function

HCSC's actions in providing health insurance benefits to federal employees are not sovereign, governmental functions that support an entitlement to removal under § 1442(a)(1).

First, HCSC can make no plausible claim to be acting on delegated authority as the licensee of a private contractor with OPM. FEHBA delegates authority *to OPM* to enter into contracts to provide health insurance, but OPM does not delegate or subdelegate *any* authority to FEHBA carriers in such contracts. *See, e.g.*, *Houston Cmty. Hosp.*, 481 F.3d at 272-73 (noting that, in Medicare context, portion of agency's statutory authority has been "delegate[d] . . . to private carriers," but that "[n]o analogous delegation of authority exists" under FEHBA). Indeed, as noted above, HCSC has no contractual relationship with the federal government. HCSC's compliance with voluntarily negotiated provisions of FEHBA contracts does not alter the analysis, any more than Philip Morris's compliance with a voluntary agreement with the Federal Trade Commission ("FTC")

made it "acting under" a federal officer in *Watson*. HCSC is not "clothed with the authority of . . . law," *Polk County*, 454 U.S. at 317-18 (internal quotations omitted), in its status as a private contractor.

Second, HCSC is not assisting in fulfilling a "basic governmental function" because the federal government itself, when contracting for health benefits for its employees, is not engaged in a sovereign, governmental task. Rather, HCSC is facilitating employment benefits in its role as employer.

It is well-settled that the government plays different roles in different contexts. In addition to acting in a sovereign capacity, the government acts in such roles as landowner, market participant, and employer. Governmental actions taken in those various roles have fundamentally different legal consequences than governmental actions taken as the sovereign. *See, e.g., Reeves, Inc. v. Stake*, 447 U.S. 429, 436-37 (1980) ("The basic distinction drawn . . . between States as market participants and States as market regulators makes good sense and sound law."); *Building & Constr. Trades Council of Metro. Dist. v. Associated Builders & Contractors of Massachusetts/Rhode Island, Inc.*, 507 U.S. 218, 229 (1993) ("[w]hen the State acts as regulator, it performs a role that is characteristically a governmental rather than a private role").

That distinction is "particularly clear" when the government acts as an employer. *See Engquist v. Oregon Dep't of Agric.*, 128 S. Ct. 2146, 2151 (2008). This Court has "often recognized that government has significantly greater leeway in its dealings with citizen employees than it does when it brings its

sovereign power to bear on citizens at large." *Id.*[11] Similarly, the Court has drawn a distinction between States acting as market participants and States acting as sovereigns. For example, when a State acts as a market participant rather than as a regulator, its actions are not constrained by the dormant Commerce Clause. *See, e.g., White v. Massachusetts Council of Constr. Employers, Inc.*, 460 U.S. 204, 208 (1983) ("[W]hen a state or local government enters the market as a participant it is not subject to the restraints of the Commerce Clause.").

Those cases establish that not all governmental activity is of a sovereign, governmental nature. Applied here, that principle compels the conclusion that HCSC – in providing health insurance services to the government as it would to private-sector employers – is not fulfilling a sovereign, governmental function warranting the exceptional protection of the federal officer removal statute. Providing health

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[11] Those additional powers as an employer, however, do not logically expand the scope of the federal officer removal statute. By contrast with military contractors, which perform services that the government itself would have to perform to discharge the Constitution's command to provide for the Nation's defense, a health insurer is simply performing a role that enables the government to compete with other private sector employers. And, whereas the purposes of the federal officer removal statute – grounded in concerns about state interference with federal governmental duties – support the necessity of removal in those limited instances in which federal power is threatened, it is quite odd, if not completely anomalous, to think that removal is necessary to vindicate any federal power prerogative in this case. First, federal-state relations will not be adversely affected if respondents' lawsuit is decided by a state court. And, second, removal under the statute should not turn on the fortuity that HCSC's service is being provided to a federal – as opposed to a state or private-sector – employee.

insurance to its employees is neither a job that the government must perform nor a quintessential sovereign function. To conclude otherwise would ignore history: the Republic existed for nearly two centuries before the federal government provided generalized health benefits to its employees. And, instead of doing so now, the government could increase the pay of its employees and allow them to purchase their own insurance directly in the private marketplace. The discretionary actions of government-as-employer do not connote a core governmental mission: "Congress did not with the FEHBA hand off a government function; rather Congress decided to get into the insurance business." *Houston Cmty. Hosp.*, 481 F.3d at 271.

HCSC's assertion that, by administering a private health insurance plan for federal employees, it is "helping the Government to produce an item [here, a service] that it needs" and "perform[ing] a job that, in the absence of a contract with a private firm, the Government itself would have had to perform," Pet. Br. 43-44, surely sweeps far too broadly.[12] To begin with, HCSC's claim is far-reaching in its scope. In fiscal year 2009, the federal government contracted with 176,422 private companies to provide goods and services valued at nearly $475 billion. *See* http://www.usaspending.gov/fpds/tables.php?tabtype=t2&subtype=t&year=2009. Each of these private contractors is helping the government produce an item that it needs and performing a job that the government

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[12] *Watson* did not hold that these criteria should be used to determine when a private contractor can invoke the federal officer removal statute. *See* 551 U.S. at 154. Instead, it simply cited them in explaining why a non-contractor's compliance with federal law was insufficient to support removal.

would have to do itself absent the contract. If HCSC could claim the protections of the federal officer removal statute on that basis, virtually *every* private contractor to the federal government sued in state court would be able to remove the case to federal court as well. Indeed, HCSC stands in a position no different from a private company chosen to provide cafeteria services to a federal agency. HCSC's theory would permit such a food services company to remove from state court a simple negligence suit brought by federal employees suffering from food poisoning.

In light of the exceptional nature of federal officer removal, establishing a firm limiting principle with respect to private contractors is crucial to prevent a dramatic expansion of federal officer removal jurisdiction. *See City of Greenwood v. Peacock*, 384 U.S. 808, 831-32 (1966); *Watson*, 551 U.S. at 153.[13] Yet HCSC offers none.

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[13] Moreover, HCSC's contention raises anomalies that make this situation a particularly poor one to expand federal officer removal beyond its historical moorings. It is extremely odd to think that federal officer removal turns on the *plaintiff*'s employment status – yet that is precisely the rule that HCSC implicitly seeks. If Ms. Pollitt were an Illinois state employee denied coverage by HCSC in precisely the same way she and her son were denied coverage here, HCSC would have no basis at all for invoking federal officer removal. Invocation by a *defendant* of federal jurisdiction to assert a federal defense should not rest on the employment status of the *plaintiff* unless the federal government itself compels the defendant in some way to undertake action under color of federal law.

c. The history and purposes of the federal officer removal statute foreclose HCSC's entitlement to removal

The history and purposes of the federal officer removal statute confirm that HCSC's expansive interpretation of the "acting under" clause should be rejected. *See, e.g., Stafford v. Briggs*, 444 U.S. 527, 535 (1980) (statutory interpretation must take account of "'the objects and policy of the law'") (quoting *Brown v. Duchesne*, 60 U.S. (19 How.) 183, 194 (1857)). The federal officer removal statute was enacted to protect weighty sovereign acts: customs officers enforcing the embargo against England during the War of 1812; federal revenue officers carrying out the Tariff of Abominations during the nullification crisis of 1833; and federal revenue officers ensuring compliance with the Nation's prohibition laws in the 1920s. It was also designed to provide protection to those private persons acting under the federal officer in carrying out these core sovereign functions. *See Watson*, 551 U.S. at 147-50. When the government itself is not engaged in a sovereign function, private entities that arguably assist it do not have a reasonable claim to federal officer removal.

That history underlies the important purposes to be vindicated by the statute, none of which is satisfied by HCSC's claim of removal. *First*, the federal officer removal statute rests on the premise that "the Federal Government 'can act only through its officers and agents, and they must act within the States. If, when thus acting, and within the scope of their authority, those officers can be arrested and brought to trial in a State court, for an alleged offence against the law of the State, . . . the operations of the general government may at any time be arrested at the will

of one of its members.'" *Willingham*, 395 U.S. at 406 (quoting *Tennessee v. Davis*, 100 U.S. 257, 263 (1880)). The statute thus provides a federal judicial forum for federal officers, as well as those aiding or assisting them, for acts undertaken in enforcing federal law and in that way "to safeguard the exercise of legitimate federal authority." *Arizona v. Manypenny*, 451 U.S. 232, 241 n.16 (1981).

That purpose reflects Congress's concern that state judicial proceedings might be used, in periods of national stress, to hinder federal officers in their enforcement of unpopular federal laws. *See id.* at 241-42 ("The act of removal permits a trial upon the merits of the state-law question free from local interests or prejudice."); *Gay v. Ruff*, 292 U.S. 25, 32 (1934). Thus, the statute reflects the "interest in protecting federal officials from possible local prejudice." *Clinton v. Jones*, 520 U.S. 681, 691 (1997).

That purpose is inapposite here. As HCSC acknowledges (at 36), the statute's "acting under" clause is designed to ensure that "a sub-delegation of authority" by a federal official to private persons does not "interfer[e] with government operations." But FEHBA carriers have not been "delegat[ed]" *any* "authority." *See Houston Cmty. Hosp.*, 481 F.3d at 272-73. Where a private entity has been delegated no authority to enforce or implement federal law and it is not assisting in carrying out a sovereign, governmental function, there is no basis for concluding that local or sectional prejudice against the federal government would arise such that state courts cannot be trusted to provide neutral forums for resolution of disputes.

Second, in addition to safeguarding those who act on delegated authority, "one of the most important

reasons for [federal officer] removal is to have the validity of the defense of official immunity tried in a federal court." *Willingham*, 395 U.S. at 407; *see also International Primate Prot. League*, 500 U.S. at 86-87 (federal officers need protection of federal forum "because of the manipulable complexities involved in determining [federal officers'] immunity"); *Acker*, 527 U.S. at 447 (Scalia, J., concurring in part and dissenting in part) ("the main point" of federal officer removal statute "is to give officers a federal forum in which to litigate the merits of immunity defenses").

That purpose, too, weighs against reading the "acting under" clause to encompass FEHBA carriers. This Court has said that "qualified immunity . . . acts to safeguard government, and thereby to protect the public at large, not to benefit its agents." *Wyatt v. Cole*, 504 U.S. 158, 168 (1992). Private actors – who "hold no office requiring them to exercise discretion" and are not "principally concerned with enhancing the public good" – are not entitled to the defense of qualified immunity. *Id.*; *see also Richardson v. McKnight*, 521 U.S. 399, 404-10 (1997). Indeed, courts of appeals have rejected the theory that FEHBA carriers – because they are not assisting in carrying out core sovereign functions – are entitled to qualified immunity. *See Houston Cmty. Hosp.*, 481 F.3d at 269 (affirming district court decision that "BCBST, as a private insurance carrier, has no substantial defense of official immunity").

Ultimately, HCSC does not seek a federal forum to protect itself from local prejudice directed at the federal government or to resolve the complexities of an official immunity defense. Instead, it seeks a federal forum to raise a preemption defense. But that objective provides no basis for stretching the statute past

its breaking point. "[S]tate courts," this Court has held, "have inherent authority, and are thus presumptively competent, to adjudicate claims arising under the laws of the United States." *Tafflin*, 493 U.S. at 458-59; *see Kircher v. Putnam Funds Trust*, 547 U.S. 633, 644 n.12 (2006); *San Remo Hotel, L.P. v. City & County of San Francisco*, 545 U.S. 323, 347 (2005). And, indeed, "a case may *not* be removed to federal court on the basis of a federal defense, including the defense of pre-emption, even if the defense is anticipated in the plaintiff's complaint, and even if both parties concede that the federal defense is the only question truly at issue." *Caterpillar*, 482 U.S. at 393; *see Chick Kam Choo v. Exxon Corp.*, 486 U.S. 140, 149-50 (1988).

2. *HCSC was not in a position of subordination or control to a federal officer*

HCSC also was not "acting under" a federal officer for a second, independent reason: OPM does not exercise sufficient control over HCSC's actions under the FEHBA contract to characterize their relationship as one of superior and subordinate. *See Watson*, 551 U.S. at 151; *but see* Pet. Br. 41-42.

HCSC is "the largest customer-owned health insurance company in the nation and the fourth largest health insurer overall." HCSC, *Operating as a Customer-Owned Health Insurer*, *at* http://hcsc.net/pdf/operating_customer_health_insurer.pdf. It provides Blue Cross and Blue Shield coverage to more than 12.4 million people. *See id.* Its Illinois division is one of at least 10 private health insurance providers competing for business among federal employees in Illinois. *See* OPM, *2010 Plan Information for Illinois*, *at* http://www.opm.gov/insure/health/planinfo/2010/states/il.asp#open (listing 10 nationwide fee-for-

services plans open to all federal employees in Illinois, as well as other plans open to specific groups of federal employees). In addition to offering coverage to federal employees, HCSC offers employer sponsored and individual plans. In all, HCSC's Illinois division insures 6.5 million people. *See generally* Blue Cross Blue Shield of Illinois, *Company Information*, *at* http://www.bcbsil.com/company_info/index.html.

As an independent licensee of BCBSA, HCSC has no direct contractual relationship with the federal government. *See* Pet. Br. 2-3. Annually, BCBSA and OPM negotiate the terms of several different plans that may be offered to federal employees. *See Empire*, 547 U.S. at 684. HCSC administers the BCBSA plan for federal employees in Illinois. *See* Pet. Br. 3. Thus, the terms under which HCSC offers health insurance to federal employees are set by a contract negotiated at arm's length between OPM and BCBSA.

FEHBA does not impose significant constraints on the contract terms negotiated by BCBSA and OPM. To the contrary, FEHBA permits OPM to approve six different types of health benefit plans: a service benefit plan; an indemnity benefit plan; an employee organization plan; and three different types of comprehensive medical plans. *See* 5 U.S.C. § 8903. FEHBA also permits OPM to contract with a broad range of insurance carriers, including "a voluntary association, corporation, partnership, or other nongovernmental organization," to offer those six plans to federal employees. *Id.* § 8901(7). Further, except for the requirement that service benefit plans and indemnity benefit plans "include benefits both for costs associated with care in a general hospital and for other health services of a catastrophic nature," *id.* § 8904(a),

OPM has broad latitude to negotiate benefits under the various plans. *See id.* ("The benefits to be provided under plans described [in this Act] *may be* of the following types") (emphasis added).

Nor do OPM regulations significantly constrain the bargaining strategy of either party. The regulations establish minimum standards in several basic areas,[14] but otherwise leave broad latitude for negotiation of virtually every aspect of the contract. The extent of that latitude is demonstrated by the significant reductions in mental health care coverage that BCSCA negotiated with OPM in the early 1980s. In 1975, BCBSA requested limitations on both inpatient and outpatient mental health benefits. *See Doe v. Devine*, 703 F.2d 1319, 1322 (D.C. Cir. 1983). OPM rejected that request. *See id.* BCBSA persisted. By 1982, OPM had agreed to a contract that reduced inpatient mental coverage from 365 days to 60 days, and outpatient mental health coverage from 70% of all medically necessary office visits to 70% of a maximum of 50 visits. *See id.* at 1322-23. In rejecting a challenge to the 1982 contract, the D.C. Circuit acknowledged the broad discretion afforded OPM in negotiating with potential carriers. *See id.* at 1325-26 & n.31. Indeed, FEHBA requires OPM to balance several conflicting goals, including the financial health of the carriers. *See id.* at 1330.

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[14] For example, plans are required to offer coverage in a nondiscriminatory fashion, provide each enrollee with an identification card, provide a standard rate structure, and maintain a special monetary reserve for the plan, *inter alia*. *See* 5 C.F.R. § 890.201(a). In addition, plans are prohibited from denying coverage for pre-existing conditions, requiring a waiting period for benefits, having more than two options and a high deductible plan, and imposing charges in addition to monthly enrollment rates. *See id.* § 890.201(b).

For these reasons, the terms of the contract under which HCSC offers health insurance to federal employees are determined in large part by arm's-length negotiations between BCBSA and OPM. BCBSA has contracted with OPM for 50 years to offer the largest nationwide health insurance plan available to federal employees. As a result, it has substantial influence over the terms and conditions of the contract that it negotiates on behalf of its affiliated carriers. In complying with the FEHBA contract, HCSC is nothing more than a subcontractor acting pursuant to market-based contractual terms set in negotiations between BCBSA and OPM. HCSC's attempt (at 41-42) to cast those terms as establishing an ongoing relationship of subordination to the federal government is unavailing. *See Watson*, 551 U.S. at 153, 156-57 (rejecting argument that company "acted under" federal officer by complying with regulations and voluntary agreement with FTC); *Orthopedic Specialists*, 518 F. Supp. 2d at 135 n.4; *Joseph v. Fluor Corp.*, 513 F. Supp. 2d 664, 672-73 (E.D. La. 2007) (compliance with minimum contractual standards did not support removal). For this additional reason, HCSC is not entitled to invoke the federal officer removal statute.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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January 25, 2010

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1. Section 301(a) of the Labor Management Relations Act, 1947, 29 U.S.C. § 185(a), provides:

(a) Venue, amount, and citizenship

Suits for violation of contracts between an employer and a labor organization representing employees in an industry affecting commerce as defined in this chapter, or between any such labor organizations, may be brought in any district court of the United States having jurisdiction of the parties, without respect to the amount in controversy or without regard to the citizenship of the parties.

2. Section 502(a)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1132(a)(1), provides:

(a) Persons empowered to bring a civil action

A civil action may be brought –

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

* * * * *

3. The National Bank Act, 12 U.S.C. § 86, provides:

The taking, receiving, reserving, or charging a rate of interest greater than is allowed by section 85 of this title, when knowingly done, shall be deemed a forfeiture of the entire interest which the note, bill, or other evidence of debt carries with it, or which has been agreed to be paid thereon. In case the greater rate of interest has been paid, the person by whom it has been paid, or his legal representatives, may recover back, in an action in the nature of an action of debt, twice the amount of the interest thus paid from the association taking or receiving the same: *Provided*, That such action is commenced within two years from the time the usurious transaction occurred.

4. The Federal Employees Health Benefits Act of 1959, 5 U.S.C. § 8901 *et seq.*, provides in relevant part:

5 U.S.C. § 8902. Contracting authority

* * * * *

(j) Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title is entitled thereto under the terms of the contract.

* * * * *

(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any

State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

* * * * *

5 U.S.C. § 8912. Jurisdiction of courts

The district courts of the United States have original jurisdiction, concurrent with the United States Court of Federal Claims, of a civil action or claim against the United States founded on this chapter.

5. Office of Personnel Management Regulations, 5 C.F.R. Pt. 890, provide in relevant part:

§ 890.105 Filing claims for payment or service.

(a) *General.* (1) Each health benefits carrier resolves claims filed under the plan. All health benefits claims must be submitted initially to the carrier of the covered individual's health benefits plan. If the carrier denies a claim (or a portion of a claim), the covered individual may ask the carrier to reconsider its denial. If the carrier affirms its denial or fails to respond as required by paragraph (c) of this section, the covered individual may ask OPM to review the claim. A covered individual must exhaust both the carrier and OPM review processes specified in this section before seeking judicial review of the denied claim.

(2) This section applies to covered individuals and to other individuals or entities who are acting on the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

* * * * *

§ 890.107 Court review.

(a) A suit to compel enrollment under § 890.102 must be brought against the employing office that made the enrollment decision.

(b) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(c) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (5 U.S.C. chapter 89). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the carrier or carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the carrier to pay the amount of benefits in dispute.

(d) An action under paragraph (c) of this section to recover on a claim for health benefits:

(1) May not be brought prior to exhaustion of the administrative remedies provided in § 890.105;

(2) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(3) Will be limited to the record that was before OPM when it rendered its decision affirming the carrier's denial of benefits.

§ 890.110 Enrollment reconciliation.

(a) Each employing office must report to each carrier or its surrogate on a quarterly basis the names of the individuals who are enrolled in the carrier's plan in a format and containing such information as required by OPM.

(b) The carrier must compare the data provided with its own enrollment records. When the carrier finds in its total enrollment records individuals whose names do not appear in the report from the employing office of record, the carrier must request the employing office to provide the documentation necessary to resolve the discrepancy.

AMICUS CURIAE BRIEF

No. 09-38

In the Supreme Court of the United States

HEALTH CARE SERVICE CORPORATION, PETITIONER

v.

JULI A. POLLITT, ET AL.

ON WRIT OF CERTIORARI
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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENTS

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QUESTIONS PRESENTED

1. Whether the Federal Employees Health Benefits Act (FEHBA), 5 U.S.C. 8901 *et seq.*, completely preempts—and therefore makes removable to federal court—a state-court suit challenging enrollment and health benefits determinations that are subject to the remedial scheme established under FEHBA.

2. Whether the federal officer removal statute, 28 U.S.C. 1442(a)(1), which authorizes removal to federal court of a state-court suit brought against a person "acting under" a federal officer when sued for actions "under color of [federal] office," encompasses a suit against a government contractor administering a FEHBA plan for actions taken pursuant to the government contract.

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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENTS

INTEREST OF THE UNITED STATES

Pursuant to the Federal Employees Health Benefits Act of 1959 (FEHBA), 5 U.S.C. 8901 *et seq.*, the Office of Personnel Management (OPM) enters into contracts with insurance carriers to provide health benefits to federal employees, annuitants, and their dependents. The United States has a substantial interest in ensuring that the roles of OPM and private carriers under FEHBA are properly understood. Further, the United States has a substantial interest in the interpretation of the federal officer removal statute.

STATEMENT

1. The Federal Employees Health Benefits Act of 1959, 5 U.S.C. 8901 *et seq.*, establishes a comprehensive

health insurance program for federal employees. FEHBA confers broad authority on OPM to administer the program and to promulgate regulations necessary to carry out the statute's objectives. 5 U.S.C. 8901-8913. FEHBA does not grant OPM authority to offer health benefit plans itself, but rather grants it authority to contract with "qualified carriers" offering such plans. 5 U.S.C. 8902, 8903.

The procedure for processing enrollment and benefit disputes under the program has evolved over time. An employee may enroll in an OPM-approved plan by submitting a request to her employing agency, for either individual or for "self and family" coverage. 5 U.S.C. 8905(a); 5 C.F.R. 890.102. Prior to 1994, the employing agency made the initial enrollment determination, subject to review by OPM. 5 C.F.R. 890.104 (1994). Now the employing agency makes both the initial and the final decision, 5 C.F.R. 890.104, subject to OPM's corrective authority, 5 C.F.R. 890.103(b). Under the current regulations, as before, any "suit to compel enrollment under 5 C.F.R. § 890.102 must be brought against the employing office that made the enrollment decision." 5 C.F.R. 890.107(a). That suit would be one under the Administrative Procedure Act (APA), 5 U.S.C. 701 *et seq.*

Prior to 1975, the governing regulations did not provide any formal administrative process for resolving disputes concerning claims for benefits by plan enrollees. The Civil Service Commission (Commission), OPM's predecessor agency, provided an informal process under which the Commission entertained employee complaints about benefit denials by carriers and could ask the carrier to reconsider the claim. See *Health Benefits: Hearing Before the Subcomm. on Compensation*

and Employment Benefits of the Senate Comm. on Post Office & Civil Service, 93d Cong., 1st Sess. 69, 72 (1973). The regulations made clear, however, that the Commission "does not adjudicate individual claims for payment or service under health benefits plans, nor does it arbitrate or attempt to compromise disputes between an employee or annuitant and his carrier as to claims for payment or service." 5 C.F.R. 890.103(d) (1974). The regulations also provided that "[a]n action to recover on a claim for health benefits" could only "be brought against the carrier of the health benefits plan." 5 C.F.R. 890.104 (1974).

In 1974, Congress amended FEHBA to provide that each contract shall require the carrier to pay for or offer a health service in an individual case if the Commission determines that the individual is entitled to the benefit under the terms of the contract. Act of Jan. 31, 1974, Pub. L. No. 93-246, § 3, 88 Stat. 4; 5 U.S.C. 8902(j). Congress was concerned that "the Commission ha[d] no legal ground upon which to demand the carrier's compliance with their decision and the employee [wa]s forced into the courts if he [wa]s to recover his judgment." H.R. Rep. No. 459, 93d Cong., 1st Sess. 7 (1973).

Following the 1974 amendment, the Commission created a formal administrative process for review of carrier decisions denying benefits. 40 Fed. Reg. 4444 (1975). But the regulations continued to provide that only "the health benefits plan," and not the Commission, "adjudicate[s] individual claims for payment or service." 5 C.F.R. 890.105(a) (1976). And, in a section entitled "Legal actions," the regulations continued to require that any "action to recover on a claim for health benefits should be brought against the carrier of the health benefits plan." 5 C.F.R. 890.104 (1976). A 1986 amendment

to the regulation further explained that "an enrollee's dispute of an OPM decision solely because it concurs in a health plan carrier's denial of a claim is not a challenge to the legality of OPM's decision. Therefore, any subsequent litigation to recover on the claim should be brought against the carrier, not against OPM." 51 Fed. Reg. 18,565 (1986); 5 C.F.R. 890.107 (1987).

In 1996, however, OPM significantly revised the framework for review of benefit denials. See 61 Fed. Reg. 15,177-15,180 (1996). Under the current regulations, "[e]ach health benefits carrier resolves claims filed under the plan," and all covered individuals must first submit their claims to the carrier. 5 C.F.R. 890.105(a)(1). If the carrier denies the claim, the covered individual may ask for reconsideration. *Ibid.* "If the carrier affirms its denial," the individual may ask OPM to review the claim. *Ibid.* A suit to review OPM's final action involving denial of a claim must be brought against OPM, not "the carrier or carrier's subcontractors." 5 C.F.R. 890.107(c); see *Empire HealthChoice Assurance, Inc.* v. *McVeigh*, 547 U.S. 677, 686-687 (2006). That action is one under the APA. *Muratore* v. *United States OPM*, 222 F.3d 918, 920 (11th Cir. 2000). The individual must exhaust administrative remedies prior to bringing the suit, 5 C.F.R. 890.107(d)(1), and the remedy is "limited to a court order directing OPM to require the carrier to pay the amount of benefits in dispute," 5 C.F.R. 890.107(c).

2. Pursuant to 5 U.S.C. 8902(a), "OPM entered into a contract in 1960 with the [Blue Cross Blue Shield Association (BCBSA)] to establish a nationwide fee-for-service health plan, the terms of which are renegotiated annually." *Empire*, 547 U.S. at 684. Petitioner, like other BCBSA affiliates, administers the Blue Cross and

Blue Shield Service Benefit Plan (Plan) on behalf of BCBSA. Pet. Br. 3; J.A. 60.

Under the contract between OPM and BCBSA, an eligible employee who wishes to enroll in the Plan must make an election to do so. J.A. 33. If the employing agency finds the employee eligible, it notifies the carrier of the election. J.A. 33-34. The carrier is then required to provide benefits as specified in the Plan brochure, J.A. 35, which explains that the "Plan is underwritten by participating Blue Cross and Blue Shield Plans (Local Plans) that administer this Plan on behalf of [BCBSA]," J.A. 60. The contract also requires the carrier to attempt to recover benefits "paid in error." J.A. 40. It specifies a number of sequential steps that "shall" be followed to recover erroneous payments, beginning with providing notice to the enrollee and "an opportunity to dispute" the debt before proceeding with collection activities. J.A. 40-42.

3. Respondent Juli Pollitt is a federal employee and enrollee in the Plan. Pet. App. 1a, 5a. Respondent Michael Nash is her former husband and the father of her minor son, but he was not covered by the Plan at any relevant time. *Id.* at 5a. While employed by the Department of Energy (DOE), Pollitt maintained coverage for herself and her son. *Ibid.* According to the allegations in the complaint, in October 2003, Pollitt went on medical leave and her employer was changed for Plan purposes to the Department of Labor (DOL), J.A. 124, presumably to DOL's Office of Workers' Compensation Programs. At some point prior to July 18, 2007, petitioner allegedly reconciled its enrollment records with those of DOL and discovered a discrepancy in enrollment codes indicating that Pollitt had "Self-only" coverage and, thus, her son was not covered. Resp. Br. 4; see 5 C.F.R.

890.110(b) (requiring such reconciliation). Pollitt's coverage was then changed to exclude her son, retroactive to October 2003. J.A. 126. Following that change, petitioner sought reimbursement of benefits paid to providers for services rendered to respondents' son between October 2003 and July 2007. J.A. 127.

Respondents filed this action in Illinois state court, alleging that petitioner acted in bad faith by disenrolling their son retroactively and failing to give prior notice of attempts to recoup payments from medical providers. J.A. 77-83. They sought an order compelling petitioner to reinstate coverage for their son, as well as compensatory and punitive damages. J.A. 81-82. Shortly thereafter, DOE sent a letter to DOL stating that the retroactive change in enrollment was a mistake and that "[s]elf and [f]amily" coverage should be reinstated. J.A. 97, 102-103. DOL forwarded a copy of that letter to petitioner, which reinstated coverage. J.A. 84.

4. After coverage was reinstated, petitioner removed the case to federal court under 28 U.S.C. 1441 on complete preemption grounds, as well as under the federal officer removal statute, 28 U.S.C. 1442(a)(1). J.A. 85-104. In a second amended complaint filed after removal, respondents alleged that petitioner had not rescinded its earlier attempts to recoup benefits. J.A. 123-133; Pet. App. 2a. The district court granted petitioner's motion to dismiss, concluding that the case was "properly removed from state court, that plaintiff Nash has no standing in this action, and that plaintiff Pollitt's claims are preempted and precluded by federal law." *Id.* at 8a.

5. The court of appeals vacated and remanded for further proceedings. Pet. App. 1a-4a. Citing *Empire HealthChoice Assurance, Inc.* v. *McVeigh*, *supra*, the court first held that there was no federal removal juris-

diction on complete preemption grounds because *Empire* "holds that federal law does not completely occupy the field of health-insurance coverage for federal workers." Pet. App. 3a.

The court held that the case might nevertheless be removable under 28 U.S.C. 1442(a)(1), which allows removal by a person "'acting under' a federal officer." Pet. App. 3a (citation omitted). The court noted that petitioner "insists that it did nothing but carry out [DOL's] instructions," while "Pollitt maintains that [petitioner] acted unilaterally in concluding that her coverage was for self only rather than self and family," as well as in attempting to recoup past benefits. *Ibid.* The court remanded for an evidentiary hearing. *Id.* at 4a. It explained that if petitioner did nothing but follow agency orders, then "the case belongs in federal court and must be dismissed" because "suits related to a federal agency's health-benefits-coverage decisions must name as the defendant [OPM] or the employing agency rather than the insurance carrier." *Ibid.* But if the agency did not direct the coverage change, the court continued, the case should be remanded to state court where the preemption defense would "be a subject for the state court's consideration." *Ibid.*

SUMMARY OF ARGUMENT

I. A. A civil action filed in state court may be removed to federal court if the plaintiff's claim "aris[es] under" federal law. 28 U.S.C. 1331, 1441(a) and (b). Whether a claim arises under federal law is governed by the well-pleaded complaint rule, which requires the federal question to appear on the face of the complaint. The "complete preemption" doctrine permits removal of purely state-law claims if a federal statute has created an exclusive federal cause of action, and the plaintiff's

state-law claims fall within the scope of that cause of action. Complete preemption is different in kind from ordinary, defensive preemption; under the former, the question is whether there is an exclusive federal statutory cause of action, not whether substantive federal law conflicts with, or even wholly displaces, state substantive law.

This Court has identified only three instances in which Congress has exercised such "extraordinary preemptive power" to support removal jurisdiction on complete preemption grounds. In all three circumstances, the federal statute that supplied the governing federal substantive law also provided an exclusive federal cause of action over which the district court had original jurisdiction.

B. In marked contrast, FEHBA does not create an exclusive statutory cause of action over which a federal district court would have original jurisdiction. The mere existence of an administrative remedy before OPM to challenge a carrier's denial of benefits does not give rise to complete preemption because it is not a judicial cause of action that could have originally been filed in federal court. And judicial review of OPM's final decision under generally applicable provisions of the APA is not the kind of "exclusive" federal statutory cause of action—*i.e.*, is not indicative of specific congressional intent to wholly displace state-law claims—sufficient to give rise to removal.

II. A. Section 1442(a)(1) grants removal rights to a federal agency or officer, as well as a private party "acting under" a federal officer. A private entity acts under a federal officer within the meaning of the statute only when it acts on behalf of the government, assisting in the performance of official duties or exercising dele-

gated authority. In those circumstances, removal gives the private party defendant a federal forum in which to raise defenses that arise from performing those official duties, and the purposes of the removal statute are furthered. Removal under Section 1442(a)(1) is most obviously implicated when private individuals are aiding law enforcement officers, but it is available whenever a private person is acting under delegated authority, or assisting the government in performing governmental functions.

B. A private contractor could be deemed to act under a federal officer, but only to the extent it is acting under delegated authority or assisting in performing governmental functions. Insurance carriers under FEHBA do not act under a federal officer for purposes of the removal statute. Carriers like petitioner enter into detailed contracts with OPM, but that does not transform the carrier from a private contractor into a federal agent. A FEHBA carrier does not perform delegated governmental functions, and does not assist OPM in performing its governmental duties. Rather, such a carrier remains in all respects a private insurance company, offering health insurance coverage and paying benefits to employees of the federal government under the terms of its contract.

ARGUMENT

I. FEHBA DOES NOT COMPLETELY PREEMPT RESPONDENTS' CLAIMS

A. The Complete Preemption Doctrine Permits Removal Only When A Federal Statute Creates An Exclusive Federal Cause Of Action

1. A civil action filed in state court may be removed to federal court if the plaintiff's claim "aris[es] under" federal law. 28 U.S.C. 1331, 1441(a) and (b). An action arises under federal law only when a federal question appears "on the face of the plaintiff 's properly pleaded complaint." *Caterpillar Inc.* v. *Williams*, 482 U.S. 386, 392 (1987); see *Louisville & Nashville R.R.* v. *Mottley*, 211 U.S. 149, 152 (1908). A defense is not part of a well-pleaded complaint; thus, when federal preemption is only a defense, as is ordinarily the case, preemption does not provide a basis for removal. *Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 207 (2004). That is so "even if the defense is anticipated in the plaintiff's complaint, and even if both parties admit that the defense is the only question truly at issue in the case." *Rivet* v. *Regions Bank*, 522 U.S. 470, 475 (1988) (quoting *Franchise Tax Bd.* v. *Construction Laborers Vacation Trust*, 463 U.S. 1, 14 (1983)).

An "independent corollary" to that rule is the principle that "a plaintiff may not defeat removal by omitting to plead necessary federal questions." *Franchise Tax Bd.*, 463 U.S. at 22. Thus, "if a federal cause of action completely pre-empts a state cause of action any complaint that comes within the scope of the federal cause of action necessarily 'arises under' federal law." *Id.* at 24. In those circumstances, "a claim which comes within the scope of that [federal] cause of action, even if pleaded in

terms of state law, is in reality based on federal law." *Beneficial Nat'l Bank* v. *Anderson*, 539 U.S. 1, 8 (2003).

2. The term "complete preemption" can be misleading; it differs from ordinary, defensive preemption not merely in degree, but in kind. Ordinary preemption, however pervasive or obvious, "does not transform the plaintiff's state-law claims into federal claims but rather extinguishes them altogether." *Rivet*, 522 U.S. at 476. It is only when an exclusive federal cause of action "wholly displace[s]" the plaintiff's state-law cause of action that the federal district court can exercise its "arising under" jurisdiction to adjudicate what is in fact (however it has been characterized) a federal claim. *Beneficial Nat'l Bank*, 539 U.S. at 8.

This Court has identified only three instances in which Congress has exercised the "extraordinary pre-emptive power" that supports removal jurisdiction on this theory. *Metropolitan Life Ins. Co.* v. *Taylor*, 481 U.S. 58, 65 (1987). First, in *Avco Corp.* v. *Aero Lodge No. 735*, 390 U.S. 557 (1968), the Court found that the "pre-emptive force" of Section 301 of the Labor Management Relations Act, 1974 (LMRA), 29 U.S.C. 185, was "so powerful as to displace entirely any state cause of action 'for violation of contracts between an employer and a labor organization.'" *Franchise Tax Bd.*, 463 U.S. at 23 (quoting 29 U.S.C. 185 and explaining the holding in *Avco*). Second, in *Metropolitan Life*, the Court held that Section 502(a)(1)(B) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1132(a)(1)(B), displaced a state-law cause of action asserting improper processing of benefits claims under an ERISA plan. 481 U.S. at 60, 66-67; see *Davila*, 542 U.S. at 209. Finally, in *Beneficial National Bank*, the Court concluded that Sections 85 and 86 of the National Bank

Act, 12 U.S.C. 85, 86, "provide the exclusive cause of action" for usury claims against national banks and completely preempt any state-law cause of action. 539 U.S. at 11. In all three of those circumstances, the federal statute that supplied the governing federal substantive law also specifically provided an exclusive federal cause of action over which federal courts had original jurisdiction. See *id.* at 8-11; *Franchise Tax Bd.*, 463 U.S. at 23 (discussing *Avco*); *Metropolitan Life*, 481 U.S. at 64-66; *Davila*, 542 U.S. at 210.[1]

Congressional intent has always been "the touchstone of the federal district court's removal jurisdiction." *Metropolitan Life*, 481 U.S. at 66. In *Metropolitan Life*, the Court was "reluctant" to allow removal, but ultimately did so for two related reasons: because "the language of the jurisdictional subsection of ERISA's civil enforcement provisions closely parallels that of § 301 of the LMRA," which gave rise to complete preemption in *Avco*; and because the legislative history made clear that Congress adopted that language to benefit from "the *Avco* rule." *Id.* at 65-66. Subsequently, this Court in *Beneficial National Bank* clarified that the "proper inquiry focuses on whether Congress intended the federal cause of action to be exclusive," not whether Congress intended the cause of action to be removable. 539 U.S. at 9 n.5; *id.* at 9 ("Only if Congress intended

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[1] The federal cause of action does not need to "precisely duplicate[]" the state-law claim. *Davila*, 542 U.S. at 216. For example, a claim may fall within the scope of an exclusive federal cause of action, and thus be removable, even if a federal court cannot award the remedy sought. See *id.* at 209; *Caterpillar*, 482 U.S. at 391 n.4.

§ 86 to provide the exclusive cause of action * * * would the statute be comparable to the provisions that we construed in the *Avco* and *Metropolitan Life* cases.").

B. FEHBA Does Not Create An Exclusive Cause Of Action Giving Rise To Complete Preemption

To permit removal of respondents' suit based on the complete preemption doctrine would require a significant extension of that doctrine.

1. Unlike the LMRA, ERISA, and the National Bank Act, FEHBA does not provide any federal cause of action against anyone, much less an exclusive cause of action against the party (the carrier) that was the defendant in the state-court suit.

a. OPM regulations assign the employing agency the responsibility to make determinations concerning eligibility for enrollment and to receive elections from employees. If an employee is dissatisfied with her agency's final decision, she may seek judicial review. But that review is available not by virtue of a specific statutory cause of action created by FEHBA, but rather by operation of the generally applicable provisions of the APA which, subject to certain exceptions inapplicable to the FEHBA program, provide a cause of action to persons aggrieved by final agency action. 5 U.S.C. 702.[2] And that APA cause of action, of course, is against the agency, not the private insurance carrier. Moreover, an APA suit would challenge only the action of the agency

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[2] The APA itself recognizes the distinction between a "special statutory review proceeding relevant to the subject matter," if one exists, and a more general cause of action for declaratory or injunctive relief against an agency "in the absence or inadequacy" of a special statutory review proceeding. 5 U.S.C. 703.

respecting the employee's eligibility for and election of coverage, not any actions of the carrier following its receipt from the agency of the notice of election.

b. With respect to claims for benefits, from the time FEHBA was enacted in 1959 until 1996, an employee's legal recourse if her carrier denied a claim was an ordinary breach of contract action against the carrier. See, *e.g.*, *Nitschke* v. *Blue Cross*, 751 P.2d 175 (Mont. 1988). That common law cause of action was not created by FEHBA; it arose merely from the carrier's status as a private insurer that had entered into an agreement. Indeed, a breach of contract action against the carrier remained the only judicial recourse even after OPM established in 1975 a formal administrative procedure to review denials of claims. Under *Beneficial National Bank* and its predecessors, because FEHBA provided no statutory cause of action against anyone, including the carrier, a suit challenging the carrier's denial of a claim under common law could not have been removed to federal court on complete preemption grounds.

OPM's revision of its regulations in 1996 does not change the outcome for complete preemption purposes. As before 1996, an employee who wants to challenge her carrier's denial of a claim for benefits may request review by OPM. And as before, if OPM concludes the claim should be paid, then under the contract the carrier is bound to pay. The primary change worked by the 1996 revision of the regulations is that if OPM concludes the claim was properly denied, a judicial action lies against OPM under the APA for an order requiring OPM to invoke its contractual right to direct the carrier to pay the claim. 5 C.F.R. 890.107(c). And, in light of the availability of that action against OPM under the APA, the regulations further provide that an employee

no longer may sue the carrier over the denial of a claim. *Ibid.* That regulation bars a state-court action against the carrier under ordinary preemption principles, thus requiring the dismissal of such a suit. But because FEHBA creates no exclusive federal statutory cause of action against the carrier (or, for that matter, against OPM) that would supplant the common law action, the necessary predicate for removal to federal court on complete preemption grounds is absent. There is, in other words, no statutory cause of action under FEHBA into which the state-law cause of action can be transformed. *Rivet*, 522 U.S. at 476.

2. As just explained, the lack of removal jurisdiction in this case follows from a straightforward application of *Beneficial National Bank* and its predecessors. There is nothing about the FEHBA program that warrants a departure from those principles.

a. The existence of an administrative remedy before OPM to challenge a carrier's denial of a claim does not give rise to complete preemption. Removal through complete preemption is premised on the proposition that, although pleaded under state law, the plaintiff's claims "necessarily 'arise under'" federal law, *Franchise Tax Bd.*, 463 U.S. at 24, and that the recharacterized federal claim "originally could have been filed in federal court," *Caterpillar*, 482 U.S. at 392. See *Rivet*, 522 U.S. at 476 ("A case blocked by the claim preclusive effect of a prior federal judgment differs from the standard case governed by a completely preemptive federal statute" because the "prior federal judgment does not transform the plaintiff's state-law claims into federal claims."). Because a right to seek administrative review by a federal agency is not a federal *judicial* cause of action that "originally could have been filed" in federal court, there

is no complete preemption. See *Sullivan* v. *American Airlines, Inc.*, 424 F.3d 267, 276 (2d Cir. 2005) (holding that the Railway Labor Act does not completely preempt state-law claims because "a state-law-based RLA minor dispute cannot be brought within the original jurisdiction of the federal courts and is thus not removable under § 1441"); *Lontz* v. *Tharp*, 413 F.3d 435, 442 (4th Cir. 2005) ("[T]he sine qua non of complete preemption is a pre-existing *federal* cause of action that can be brought in the district court."). To conclude otherwise would uncouple the complete preemption doctrine from its moorings and greatly expand its scope.

b. The same would be true if removal under the complete preemption doctrine were allowed based on the availability of judicial review under the APA following OPM's final administrative decision. Three factors, especially when considered together, compel that conclusion.

First, respondents' claims against the carrier do not come within the scope of the APA cause of action. An APA action is brought against OPM, not against the carrier, and the action challenges the final decision of the agency, not the carrier's denial of a claim prior to administrative review. The lack of identity of the defendants in the federal and state actions might not be dispositive in some other settings. But here, where the defendant in the federal action is an agency of the United States Government and the defendant in the state common law action is a private party, the Court should be especially reluctant to view as essentially the same a state-law claim against one party and a federal-law claim against another.

Second, a holding that an APA suit is the kind of "exclusive" federal cause of action that can support removal

on complete preemption grounds would vastly expand the reach of this judicial gloss on the federal jurisdiction statutes. As petitioner notes, the APA "presumptively" applies whenever there is a challenge to final agency action. Pet. Br. 18. The sweep of removal jurisdiction on petitioner's view thus would seem to encompass all cases in which some aspect of the state-law claim also could have been addressed to a federal agency (since, presumptively, all such matters would then be subject to judicial review under the APA). Acceptance of such a theory would expand the scope of federal jurisdiction beyond what Congress has authorized or this Court has countenanced, at the expense of the federal-state balance and in derogation of a plaintiff's ability, within the confines of the well-pleaded complaint rule, to frame her suit as she chooses.

Third, the existence of an APA cause of action against OPM is the consequence of regulations issued by OPM, not specific congressional design. Ordinarily, action by an Executive agency does not alter the jurisdiction of the federal courts. See *Carlyle Towers Condo. Ass'n* v. *FDIC*, 170 F.3d 301, 310 (2d Cir. 1999) (It has generally been thought "'axiomatic' that agencies can neither grant nor curtail federal court jurisdiction.") (quoting *Miller* v. *FCC*, 66 F.3d 1140, 1144 (11th Cir. 1995), cert. denied, 517 U.S. 1155 (1996)); cf. *Kucana* v. *Holder*, No. 08-911 (Jan. 20, 2010), slip op. 16-17 (declining to read statute as delegating authority to the Executive to preclude judicial review).

3. Petitioner attempts to tease out congressional intent to create an exclusive federal cause of action sufficient to trigger complete preemption from three statutory provisions: (1) 5 U.S.C. 8912, which confers jurisdiction on the federal district courts, concurrent with

that of the Court of Federal Claims, over actions against the United States under FEHBA; (2) 5 U.S.C. 8902(j), which makes OPM benefit determinations binding on the carrier as a matter of contract; and (3) the 1998 amendment to 5 U.S.C. 8902(m)(1), FEHBA's express preemption provision. These arguments are unavailing.

Section 8912 was part of the 1959 Act, and has not changed in any material respect in the ensuing half-century. FEHBA, Pub. L. No. 86-382, § 15, 73 Stat. 716. In 1959, there were no FEHBA regulations at all—and certainly no regulations channeling challenges to carriers' benefit denials first to OPM and then to an action for judicial review against OPM under the APA. Section 8912 therefore cannot be read to suggest that Congress intended to limit benefit disputes under FEHBA to suits brought against the United States. Rather, as the Court explained in *Empire*, "[t]he purpose of this provision—evident from its reference to the Court of Federal Claims—was to carve out an exception to the statutory rule that claims brought against the United States and exceeding $10,000 must originate in the Court of Federal Claims." 547 U.S. at 686; see *id.* at 710 (Breyer, J., dissenting).

Nor did Congress, in enacting Section 8902(j) in 1974, intend to trigger complete preemption. Petitioner argues that the creation of OPM's administrative mechanism for review of claim denials was in response to Section 8902(j)'s "instruction," and was "plainly" designed to "implement Congress's intent." Pet. Br. 24, 41, 43. But the OPM review mechanism, as initially adopted in 1975, did not preclude covered individuals from suing carriers in court: indeed, it specified that any subsequent legal action was to be filed against the carrier, rather than OPM. OPM's subsequent regulatory deci-

sion that judicial challenges to benefit denials should be brought as suits against OPM in federal court can hardly suggest a congressional intent to that effect in 1974, more than two decades prior to the agency action.[3]

Finally, petitioner errs in relying on Congress's amendment in 1998 to Section 8902(m)(1), FEHBA's preemption provision. Under that provision, certain FEHBA contract terms supersede state or local law or

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[3] The United States informed the Court of this regulatory decision in *Rocky Mountain Hospital & Medical Service* v. *Phillips*, 513 U.S. 1071 (1995). In that case, this Court granted certiorari to decide whether federal question jurisdiction existed over an action brought by a carrier seeking a declaration that it was not obligated to provide certain health insurance benefits under a FEHBA plan. The United States amicus brief described the jurisdictional issue as difficult because federal law would govern so much of the dispute, although it did not take a definitive position on the issue. See U.S. Br. at 12-18, *Rocky Mountain Hosp.*, *supra* (No. 94-555) (94-555 U.S. Br.) Instead, the United States suggested that dismissal of the writ would be warranted in light of OPM's recently promulgated interim regulations, see 60 Fed. Reg. 16,037 (1995), providing that an enrollee must sue OPM directly under the APA. 94-555 U.S. Br. at 8, 10-11. Because federal jurisdiction would clearly exist over such APA actions against OPM, and because any claim brought by an enrollee against the carrier (instead of OPM) in state or federal court would be preempted, the question presented ceased to have continuing importance. *Id.* at 23.

As particularly relevant here, the government explained that as a result of the new regulation, "[f]uture cases in which an enrollee sues a carrier for FEHBA benefits" likely will only raise a defensive preemption question—*i.e.*, whether the case "must be dismissed because it is preempted by the action for administrative review now available against OPM." 94-555 U.S. Br. at 23. Because "[t]hat is a simple, up-or-down preemption question * * * that state courts typically resolve successfully in other federal regulatory areas," concerns of "disuniformity" between "federal or state courts" would be minimal. *Ibid.* The *Rocky Mountain Hospital* case was dismissed before decision pursuant to Supreme Court Rule 46. 514 U.S. 1048 (1995).

regulations that "relate to health insurance or plans." 5 U.S.C. 8902(m)(1). The 1998 amendment deleted the following limitation on that provision: "to the extent that such law or regulation is inconsistent with such contractual provisions." H.R. Rep. No. 374, 105th Cong., 1st Sess. 22 (1997) (*House Report*). Petitioner contends that this amendment was meant to respond to lower court decisions denying removal on complete preemption grounds. Pet. Br. 29. But it seems far more likely that Congress intended to do just what the omission of the relevant text accomplished—broaden the extent to which FEHBA contract terms would preempt state or local substantive law relating to benefits.[4]

Nothing in the text of Section 8902(m)(1) speaks to the jurisdiction of the federal courts or to the remedial scheme, including APA review, that OPM created. And

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[4] Petitioner also overstates (Pet. Br. 28-29) the extent to which lower courts had relied on the limitation in Section 8902(m)(1) to reject complete preemption in FEHBA cases. For example, in *Goepel* v. *National Postal Mail Handlers Union*, 36 F.3d 306 (3d Cir. 1994), cert. denied, 514 U.S. 1063 (1995), the court did not rely on the relative breadth of the express preemption provision in ERISA, as compared to FEHBA; it instead explained that ERISA "contains a civil enforcement provision expressly authorizing ERISA beneficiaries to bring actions to recover benefits under an ERISA plan," whereas "FEHBA does not create a cause of action." *Id.* at 312. The two district court cases cited by petitioner (Pet. Br. 28) also noted that "FEHBA does not provide a civil enforcement provision to replace the preempted state law causes of action." *Transitional Hosps. Corp.* v. *Blue Cross & Blue Shield of Tex., Inc.*, 924 F. Supp. 67, 69 (W.D. Tex. 1996); see *Arnold* v. *Blue Cross & Blue Shield of Tex., Inc.*, 973 F. Supp. 726 (S.D. Tex. 1997) (same). If Congress had intended to trigger removal jurisdiction, it could have addressed that issue directly, either by creating a federal cause of action or by amending the removal statute; Congress would not likely have chosen simply to delete language from the express preemption provision, with no mention at all of jurisdiction.

the legislative history makes no mention of the federal administrative remedy. As petitioner notes, the committee reports did speak of encouraging "uniformity" and "completely displac[ing]" state law, Pet. Br. 28-29, but that is relevant to the scope of substantive preemption —*i.e.*, whether FEHBA "contract terms" should "displace" all (not just conflicting) state substantive law, rather than whether a federal cause of action "displaces" a state-law cause of action.

The only language touching on federal jurisdiction, as opposed to substantive preemption, is a passing statement that the "change will strengthen the case for trying FEHB program claims disputes in Federal courts rather than State courts." *House Report* 9. But, as then-Judge Sotomayor explained, "it is something of a mystery what the authors of the report meant * * * [g]iven that (1) section 8902(m)(1) is by its plain and unambiguous terms a preemption provision and not a grant of jurisdiction, and (2) the legislative history provides only limited and equivocal support for a contrary conclusion." *Empire HealthChoice Assurance, Inc.* v. *McVeigh*, 396 F.3d 136, 149 n.16. (2d Cir. 2005), aff'd, 547 U.S. 677 (2006). And in fact by the time of the amendment, OPM regulations already provided for "FEHB program claims disputes" to be heard "in Federal courts rather than State courts," *House Report* 9, as a result of the 1996 regulations providing for actions against OPM under the APA. The single comment in the House Report therefore falls far short of "strongly support[ing]" complete preemption, Pet. Br. 29-30. See *Empire*, 547 U.S. at 698 (if "Congress intends a preemption instruction completely to displace ordinarily applicable state law, and to confer federal jurisdiction thereby, it may be expected to make that atypical intention clear").

4. Petitioner also relies on *Empire*, in conjunction with *Clearfield Trust Co.* v. *United States*, 318 U.S. 363 (1943), to argue that there is a strong federal interest requiring uniform rules in this context and that this interest demands that federal law displace state law and removal jurisdiction be available. The government concurs with all but the last part of this argument. The government agrees that OPM's administrative review scheme is exclusive, and that claims within its scope cannot be pursued in the courts (either state or federal) in the first instance. The government believes that judicial challenges to denials of claims can be brought against OPM alone, under the APA, after exhausting administrative remedies. And the government shares petitioner's concern that evasions of this process could adversely affect federal employees and their health benefit plans. All of that explains why petitioner may have a strong preemption *defense* in state court. But none of it establishes complete preemption. See *Caterpillar*, 482 U.S. at 398 ("The fact that a defendant might ultimately prove that a plaintiff's claims are pre-empted * * * does not establish that they are removable to federal court."). To satisfy the well-pleaded complaint rule, there must be an exclusive federal cause of action within the original jurisdiction of the federal courts into which the state-law claim can be transformed. *Rivet*, 522 U.S. at 476. There is no such federal cause of action here.

II. A PRIVATE CARRIER THAT CONTRACTS TO PROVIDE HEALTH INSURANCE TO FEDERAL EMPLOYEES UNDER FEHBA IS NOT "ACTING UNDER" A FEDERAL OFFICER WITHIN THE MEANING OF 28 U.S.C. 1442(a)(1)

Section 1442(a)(1) affords a right of removal to "any officer (or any person acting under that officer) of the United States or of any agency thereof, sued in an official or individual capacity for any act under color of such office." 28 U.S.C. 1442(a)(1). The federal officer removal statute permits removal even when the federal question arises only by way of a defense to a state-law claim. See *Jefferson County* v. *Acker*, 527 U.S. 423, 431 (1999). For a private party to secure removal under Section 1442(a)(1), however, the defendant must be "acting under" a federal officer. A private person acts under a federal officer within the meaning of the statute only when that person acts on behalf of the federal officer under delegated authority, or by "assist[ing]" or "help[ing] carry out" the official "duties or tasks of the federal superior." *Watson* v. *Phillip Morris Cos.*, 551 U.S. 142, 152 (2007) (emphasis omitted). Petitioner cannot satisfy that test.

A. The Text, History, And Purposes Of Section 1442(a)(1) Make Clear That Removal By Private Parties Is Permitted Only When They Act On Behalf Of A Federal Officer Under Delegated Authority Or By Assisting In The Performance Of His Official Duties

1. As the Court has recounted on many occasions, most recently in *Watson*, the current version of the federal officer removal statute is the end-product of a series of congressional enactments beginning in the early years of our Nation's history. See *Watson*, 551 U.S. at 147-148; *Willingham* v. *Morgan*, 395 U.S. 402, 405-406

(1969). The early statutes were passed in response to state-court hostility directed at certain unpopular federal laws and the federal officers charged with enforcing them. See *id.* at 405 (first removal statute prompted by trade embargo with England "over the opposition of the New England States, where the War of 1812 was quite unpopular"); *ibid.* (removal statute enacted after South Carolina declared federal tariff laws unconstitutional and authorized prosecution of federal agents); *id.* at 405-406 (removal statutes adopted to address "cases growing out of enforcement of the revenue laws" during and after Civil War).

Those predecessor statutes authorized removal of civil and criminal state-court actions brought against certain classes of federal officers, such as customs collectors and revenue officers, as well as persons assisting those officers in performing their official duties. Act of Feb. 4, 1815, ch. 31, §§ 6, 8, 3 Stat. 197-198 (removal by a federal customs officer and "any other person aiding or assisting" him); Act of Mar. 2, 1833, ch. 57, § 3, 4 Stat. 633 (removal by "any officer of the United States, or other person, for or on account of any act done under the revenue laws of the United States"); Act of July 13, 1866, ch. 184, § 67, 14 Stat. 171-172 (removal of suit against revenue officer "on account of any act done under color of his office," or "any person acting under or by authority of any such officer" "for the collection of taxes"). In *Davis* v. *South Carolina*, 107 U.S. 597 (1883), removal was permitted when a corporal of the United States infantry was detailed to assist a revenue officer in making an arrest under the revenue laws. The Court held that "the protection which the law thus furnishes to the marshal and his deputy, also shields all who lawfully assist [a revenue officer] in the perform-

ance of his official duty." *Id.* at 600; see *Maryland* v. *Soper*, 270 U.S. 9, 30 (1926) (rejecting removal jurisdiction but noting that a private person acting "as a chauffeur and helper to [prohibition officers]" during a distillery raid would be entitled to removal to the same extent as the officers).

In 1948, Congress expanded the right of removal to encompass all federal officers. Act of June 25, 1948, ch. 646, § 1442, 62 Stat. 938.[5] The House Report described the amendment as "extend[ing removal] to apply to all officers and employees of the United States or any agency thereof." H.R. Rep. No. 308, 80th Cong., 1st Sess. A-134 (1947). But "[w]hile Congress expanded the statute's coverage to include all federal officers, it nowhere indicated any intent to change the scope of words, such as 'acting under,' that described the triggering relationship between a private entity and a federal officer." *Watson*, 551 U.S. at 149.

In *Watson*, this Court summed up the historical understanding: to be "acting under" a federal officer, a private person must be involved in "an effort to *assist*, or to help *carry out*, the duties or tasks of the federal superior." 551 U.S. at 152; cf. *City of Greenwood* v. *Peacock*, 384 U.S. 808, 824 (1966) (interpreting related removal provision as permitting private party to remove only when "authorized to act with or for [federal officers] in affirmatively executing duties under any federal law"). The surrounding statutory text confirms that understanding by speaking in terms of acts performed "under color of [federal] office." 28 U.S.C. 1442(a)(1).

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[5] With the exception of a 1996 revision made in response to the Court's decision in *International Primate Protection League* v. *Administrators of Tulane Educational Fund*, 500 U.S. 72 (1991), that codification controls today.

A private entity can be said to be acting "under color of federal office" only when it is exercising or assisting in the exercise of official authority in carrying out a government function.

2. That reading effectuates the purposes of the federal officer removal statute, without unduly intruding on federal-state relations. For over a century, such statutes have been grounded in the overriding concern that "[s]tate-court proceedings may reflect 'local prejudice' against unpopular federal laws or federal officials," *Watson*, 551 U.S. at 150; because the federal government "can act only through its officers and agents," if "those officers can be arrested and brought to trial in a State court, * * * the operations of the general government" would suffer. *Tennessee* v. *Davis*, 100 U.S. 257, 263 (1880). In response to those concerns, Section 1442(a)(1) and its predecessors were enacted "to provide a federal forum for cases where federal officials must raise defenses arising from their official duties." *Willingham*, 395 U.S. at 405; see *Mesa* v. *California*, 489 U.S. 121, 137 (1989); *Arizona* v. *Manypenny*, 451 U.S. 232, 241 (1981). Indeed, "one of the most important" reasons for removal is to have a federal court adjudicate official immunity defenses. *Watson*, 551 U.S. at 150 (quoting *Willingham*, 395 U.S. at 407); see *Manypenny*, 451 U.S. at 242. A suit against a private person implicates those concerns when he is "act[ing] as an assistant to a federal official in helping that official to enforce federal law" or to "perform[] * * * his official duty." *Watson*, 551 U.S. at 151 (citation omitted).

As the history and purpose of the removal statute suggest, the basis for federal officer removal continues to be most obviously implicated when private persons are aiding law enforcement activity. For example, in

Camacho v. *Autoridad de Telefonos*, 868 F.2d 482 (1st Cir. 1989), telephone companies participated in the wiretapping of certain phone lines under the direction of federal agents. Because the companies were assisting federal officers engaged in "official government business," and were doing so at "federal behest," the court properly held that they were "acting under" federal officers within the meaning of the statute. *Id.* at 486; cf. *Venezia* v. *Robinson*, 16 F.3d 209 (7th Cir.) (removal by state employee who solicited bribe as part of sting operation conducted by FBI agents), cert. denied, 513 U.S. 815 (1994).

The removal statute has also been applied outside the law enforcement context to private persons acting on behalf of the federal government, assisting in the performance of official duties or exercising delegated authority. For example, removal was available to the inspector of an aircraft engine who was named by the Director of the Federal Aviation Administration as a "designated manufacturing inspection representative" pursuant to the Director's statutory authority to "delegate to any properly qualified private person." *Magnin* v. *Teledyne Cont'l Motors*, 91 F.3d 1424, 1428 (11th Cir. 1996) (citation omitted). Likewise, a bank designated as a "depository and financial agent" of the United States providing banking services on a military base under the authority of the Secretary of the Treasury asserted at least a "colorable" claim of "acting under" a federal officer. *Texas* v. *National Bank of Commerce*, 290 F.2d 229, 231-232 (5th Cir.), cert. denied, 368 U.S. 832 (1961).

B. Private Carriers That Contract With The Federal Government To Provide Health Insurance To Federal Employees Under FEHBA Are Not "Acting Under" A Federal Officer

This Court has not decided "whether" or "when" private contractors come within the terms of the federal officer removal statute. *Watson*, 551 U.S. at 154. In *Watson*, the Court held that simple compliance with the law—even when a regulatory scheme entails a high level of detail, supervision, and monitoring—is not sufficient to place a private party within the scope of "acting under." *Id.* at 152-153. In explaining why a government contractor case could present a different situation, the Court observed that private contractors "help[] the Government to produce an item that it needs" and, "at least arguably," some may perform a job "that, in the absence of a contract with a private firm, the Government itself would have had to perform." *Id.* at 153-154. The Court distinguished on that basis a case involving a contractor that supplied the government with Agent Orange to help conduct the war in Vietnam. *Ibid.* (discussing *Winters* v. *Diamond Shamrock Chem. Co.*, 149 F.3d 387 (5th Cir. 1998), cert. denied, 526 U.S. 1034 (1999)). The Court found that distinction "sufficient" "[f]or present purposes," but did not decide "whether and when particular circumstances may enable private contractors to invoke the statute." *Id.* at 154.

Those circumstances should be no different than for other private parties. To the extent a private contractor can be deemed to be acting on behalf of the government, assisting in the performance of its official duties or exercising delegated authority, the "acting under" prerequisite would be satisfied. Mere compliance with detailed contractual terms, however, does not render a private

party an agent of the federal government, any more than compliance with detailed and pervasive federal regulations does.

As this Court recognized, an expansive interpretation of "acting under" would "potentially" bring a wide variety of state-court actions within the scope of the federal officer removal statute, and so within the sphere of federal judicial power. *Watson*, 551 U.S. at 153. Although not as expansive as the interpretation urged in *Watson*, a reading of "acting under" that encompasses all private parties to detailed and supervised government contracts could materially alter the allocation of federal and state jurisdiction without significantly furthering the historical purposes underlying the federal officer removal statute. There is no need to canvass the full range of contractual relationships and identify those in which removal would be proper. In this case, distinctive features of the FEHBA program serve to separate OPM from the carriers in a way that demonstrates that the carriers are not "acting under" OPM for purposes of the removal statute.

FEHBA reflects Congress's judgment to award contracts annually on a competitive and arms-length basis to carriers prepared to offer attractive benefits packages to federal employees. Congress sought to "ensure maximum health benefits for employees 'at the lowest possible cost to themselves and to the Government.'" *Doe* v. *Devine*, 703 F.2d 1319, 1329 n.41 (D.C. Cir. 1983) (R.B. Ginsburg, J.) (quoting H.R. Rep. No. 957, 86th Cong., 1st Sess. 4 (1959)). Accordingly, a FEHBA carrier "freely enters into the market, in which * * * carriers 'compete vigorously' with other providers for customers within the pool of federal employees." *Houston Cmty. Hosp.* v. *Blue Cross & Blue Shield of Tex., Inc.*,

481 F.3d 265, 272 (5th Cir. 2007) (citation omitted) (holding that a Blue Cross Blue Shield subsidiary did not perform a government function for purposes of official immunity when it participated in FEHBA). When a carrier enters into a contract with OPM, it bears the underwriting risk "to provide health benefits * * * whether or not the sum of the charges [for benefits] exceed[s] the sum of the subscription income." *Christiansen* v. *National Sav. & Trust Co.*, 683 F.2d 520, 523 (D.C. Cir. 1982) (asterisks and brackets in original) (citation omitted).[6]

Carriers thus act in a private capacity to offer health insurance coverage and pay benefits for the employees of the federal government, just as they do for the employees of companies in the private sector. A carrier does not do the work of the government in providing insurance coverage to federal employees, any more than it does the work of a private corporation in providing coverage to the corporation's employees. See *Hayes* v. *Prudential Ins. Co.*, 819 F.2d 921, 922 (9th Cir. 1987) ("[T]he United States does not act as an insurer."), cert. denied, 484 U.S. 1060 (1988). A carrier is an independent party that has entered into a contractual relationship for agreed-upon remuneration. It is not exercising, nor has the government granted it authority to exercise, any public powers.

A comparison with the role of insurance companies as carriers and fiscal intermediaries under the Medicare program (see Pet. Br. 45 n.3) underscores this fundamental point. Medicare is a health insurance program established, maintained, and underwritten by the fed-

[6] The underwriting risk assumed by the plans is offset in a number of ways but, as petitioner acknowledges (Pet. Br. 54 n.5), it is not eliminated altogether. *Christiansen*, 683 F.2d at 523.

eral government itself. To administer the program, the Center for Medicaid and Medicare Services in the Department of Health and Human Services "delegates a portion of its statutory functions to private carriers under 42 C.F.R. § 421.5(b)." *Houston Cmty. Hosp.*, 481 F.3d at 272-273. By virtue of this delegation, carriers and fiscal intermediaries, *inter alia*, make initial benefit and reimbursement determinations on behalf of the government. See *Your Home Visiting Nurse Servs.* v. *Shalala*, 525 U.S. 449, 451 (1999) (fiscal intermediaries under Medicare act as the "Secretary's agent"); *Schweiker* v. *McClure*, 456 U.S. 188, 190 (1982) (explaining that private insurance carriers act "on [the Secretary's] behalf" in administering payment of Part B claims).

In contrast, FEHBA carriers perform no such outsourced government tasks, exercise no delegated authority, and never act on behalf of OPM. They function as private and independent economic entities that offer and run their own health insurance plans. The employing agency does determine whether an employee is eligible to enroll and forwards the election to the carrier. But that is just an initial gateway function to assure that the employee has the requisite employment relationship and other qualifications to participate. The carrier's obligation to pay benefits to the enrollee under the plan then flows from the terms of its contract.

Nothing relating to OPM's administrative review process affects this analysis. As described earlier, OPM may demand that the carrier pay benefits on a particular claim if administrative review reveals that these benefits are due under the contract. But that is simply the consequence of a term in the carrier's contract with OPM, as required by 5 U.S.C. 8902(j), which enables

OPM to supervise contractual performance. The carrier acts independently, by means of its own internal processes and rules, in deciding claims presented to it and thereby fulfilling its own contractual obligations. OPM's role in enforcing the carrier's compliance with contract terms does not transform the carrier into a governmental agent, exercising delegated power or assisting the government in performing public functions. *Watson*, 551 U.S. at 157 ("neither Congress nor federal agencies normally delegate legal authority to private entities without saying that they are doing so"). The private insurance carrier remains just that, performing under the terms of its contract with the government as it would with any other party.[7]

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[7] Because petitioner is not "acting under a federal officer" within the meaning of Section 1442(a)(1) when it performs under the terms of its contract with OPM, the Court need not decide whether there is a "'causal connection' between the charged conduct and asserted official authority," *Acker*, 527 U.S. at 431 (citation omitted). The case-by-case approach to that question adopted by the court of appeals (Pet. App. 3a-4a), however, threatens to impair, rather than protect, government operations. The evidentiary hearing envisioned by the court would require inquiry into governmental decision-making in a suit in which the government is not a party, and would result in a needless expenditure of government resources serving only to delay adjudication of the merits in the proper forum.

CONCLUSION

The judgment of the court of appeals should be vacated and remanded with instructions that the case be remanded to state court.

Respectfully submitted.

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FEBRUARY 2010

AMICUS CURIAE BRIEF

SUPREME COURT, U.S.
FILED
DEC 10 2009
OFFICE OF THE CLERK

No. 09-38

In the
Supreme Court of the United States

HEALTH CARE SERVICE CORPORATION,

Petitioner,

v.

JULI A. POLLITT and MICHAEL A. NASH,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF OF *AMICUS CURIAE* AETNA INC. IN SUPPORT OF PETITIONER

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INTEREST OF THE *AMICUS CURIAE*

Aetna Inc., through its operating subsidiaries (collectively "Aetna"), is one of the largest providers of health care benefits in the United States.[1] Aetna offers managed care plans, health savings accounts, and traditional indemnity coverage, along with dental, vision, behavioral health, and Medicare plans. Aetna offers federal employees and their dependents multiple health care plans under the Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901-8914 ("FEHBA"). Aetna offers federal employees a consumer-driven/high-deductible health plan that operates in all fifty states and the District of Columbia, and comprehensive medical plans (commonly known as "HMOs") that operate in fourteen states and the District of Columbia. In 2008, Aetna processed almost $1.1 billion in health care benefits for covered federal employees and their dependents. In 2009, over 321,000 federal and postal employees and annuitants, plus their dependents, were enrolled in Aetna plans.

Aetna administers health benefits for federal employees and their dependents pursuant to standard form federal agency procurement contracts identical to petitioner's procurement contract in all material respects. The Court's decision, therefore,

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[1] Pursuant to Rule 37.6 of the Rules of this Court, *amicus* states that this brief was not authored in whole or in part by counsel for a party and that no person or entity, other than the *amicus curiae* and its counsel, made a monetary contribution to its preparation and submission. The written consents of the parties to the filing of this brief have been filed with the Court.

will have a significant financial and administrative impact on Aetna. Aetna, therefore, respectfully requests that the Court consider its views as to the first issue presented—whether FEHBA completely preempts state law claims challenging enrollment and health benefits decisions that are subject to the exclusively federal remedial scheme established in FEHBA.[2]

INTRODUCTION AND SUMMARY OF ARGUMENT

At the time of removal to federal court, the complaint filed in this action attempted to assert state law claims for insurance coverage and benefits. The coverage and benefits sought in the complaint were claimed through respondent Juli Pollitt ("Ms. Pollitt"), a federal employee enrolled in a federal health benefit plan. Federal employee health care benefits were created and authorized by an act of Congress, are regulated by and contracted through the United States Office of Personnel Management ("OPM"), and provided through health benefit plan carriers ("carriers"). The tripartite relationship among federal employees, OPM, and carriers is exclusively governed by federal law. Federal law further provides the exclusive cause of action for any claim for coverage or benefits arising from that tripartite relationship. Thus, any state law claims by federal employees seeking health care coverage and benefits under a contract between

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[2] Aetna supports petitioner's argument with respect to the second issue on appeal, but writes only with respect to the first issue.

OPM and a carrier are completely preempted and subject to removal to federal court.

As a matter of constitutional prerogative, Congress is invested with the exclusive authority to determine the benefits available to federal employees. Congress exercised that exclusive authority by enacting legislation authorizing health care benefits for federal employees. As part of that legislation, Congress delegated to OPM the authority to negotiate and regulate federal employee health benefit plans. Pursuant to this congressional delegation of authority, OPM adopted regulations requiring an employing federal agency to determine coverage (enrollment) and OPM to determine benefits. In order to close the loop on this three-party relationship, OPM also adopted regulations, consistent with FEHBA, mandating that carriers follow federal agency and OPM decisions with respect to coverage and benefits.

Consistent with this decision-making authority, and pursuant to the congressional delegation of authority, OPM adopted regulations establishing a detailed and reticulated scheme for federal employees to follow for resolving disputes concerning enrollment and benefits, including procedures for administrative review, available remedies, and judicial review. Indeed, the OPM regulations created an exclusive federal cause of action by allowing federal employees to seek judicial review of final coverage (enrollment) decisions made by the employing federal agency and final benefit decisions made by OPM. Based on the exclusive authority of

Congress to determine federal employee benefits, the tripartite relationship designed by Congress, the congressional delegation of authority to OPM to negotiate and regulate federal employee health benefits, and OPM's exercise of that authority, the Court should find the federal cause of action exclusive for any federal employee claiming health care coverage or benefits. The Court should further find any state law claims for coverage or benefits completely preempted.

The exclusivity of the federal cause of action is further supported by the incorporation of FEHBA and its regulations into the standard form contract between OPM and the carriers. Indeed, the FEHBA preemption provision expressly provides that "[t]he terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." Given the incorporation of the exclusive federal remedial scheme into the OPM/carrier contracts, and the express preemption provision mandating that contract terms relating to coverage and benefits supersede state law, the Court should find complete preemption and sustain the removal to federal court.

ARGUMENT

A civil action filed in state court may be removed to federal court if the complaint sets forth a claim "arising under" federal law. *See* 28 U.S.C. § 1441(b). Whether a claim arises under federal law is typically determined from the "well-pleaded" allegations of the complaint. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 207 (2004). The complete preemption doctrine is an exception to the well-pleaded complaint rule. *See Beneficial Nat'l Bank v. Anderson*, 539 U.S. 1, 5 (2003). "[W]hen a federal statute wholly displaces the state-law cause of action through complete pre-emption," the purported state law claim can be removed. *See id.* at 8. Such claims are removable because, "[w]hen the federal statute completely pre-empts the state-law cause of action, a claim which comes within the scope of that cause of action, even if pleaded in terms of state law, is in reality based on federal law." *See id.* Indeed, the preemptive scope of federal law cannot be avoided by labeling a federal claim as a state law cause of action. *See Davila*, 542 U.S. at 214-15.

I. RESPONDENTS' STATE LAW CLAIMS ARE COMPLETELY PREEMPTED BY FEHBA AND ITS REGULATORY SCHEME.

A. Congress Is Constitutionally Empowered With The Exclusive Authority To Determine The Benefits Available To Federal Employees And Delegated To OPM The Authority To Implement Necessary Regulations.

Congress was authorized to enact FEHBA pursuant to Article I, Section 1, of the United States Constitution, granting legislative authority to Congress, and Article I, Section 8, the "Necessary and Proper" clause of the Constitution. *See* U.S. Const. art. I, § 1; § 8, cl. 18. Indeed, Congress specifically cited the Necessary and Proper Clause as the constitutional authority for the 1998 amendment to FEHBA. *See* H.R. Rep. No. 105-374, at 19 (1997).

The "Necessary and Proper" clause confers upon Congress the power "[t]o make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers, and all other Powers vested by this Constitution in the Government of the United States, or in any Department or Officer thereof." *See* U.S. Const. art. I, § 8, cl. 18. At least since *McCulloch v. Maryland*, 17 U.S. 316 (1819), the Necessary and Proper Clause has been interpreted as authorizing Congress "to exercise its best judgment in the selection of measures to carry into execution the constitutional powers of government." *See id.* at 420.

This Court similarly recognized that Congress, acting through the Necessary and Proper Clause, is empowered to make laws providing for the operation of the federal government. *See, e.g., United States v. Stanley*, 483 U.S. 669, 682 n.6 (1987) (acknowledging congressional authority under Necessary and Proper Clause "to make rules for the government and regulation of the Postal Service"). Similarly, courts have long recognized congressional power over the compensation and benefits available to federal employees. *See Kizas v. Webster*, 707 F.2d 524, 536 (D.C. Cir. 1983); *Puglisi v. United States*, 564 F.2d 403, 409 (Ct. Cl. 1977) ("Setting the pay of federal officers and employees is, historically and constitutionally, within Congress's power.").

Ordinary contract principles are inapplicable in determining federal employee compensation and benefits; the compensation and benefits available to federal employees is determined by federal statutes and regulations. *See Kizas*, 707 F.2d at 535 (rejecting claim that federal employees had vested contractual right in special hiring preference not found in federal statutes or regulations). In *Kizas*, the court explained how Title 5 of the United States Code provides the exclusive source of federal employee compensation:

> Title 5 of the United States Code and its implementing regulations set forth in meticulous detail the compensation that attaches to positions in the government service. These provisions govern all

> incidents of employee compensation, including basic salaries; salary increases; overtime, holiday and sick pay; life and health insurance benefits; retirement benefits; travel and subsistence allowances; and compensation for injury and unemployment.

Kizas, 707 F.2d at 536 (footnotes omitted).

FEHBA is part of Title 5 and "establishes a comprehensive program of health insurance for federal employees." *See Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 682 (2006). Congress enacted FEHBA to provide "a measure of protection for civilian Government employees against the high, unbudgetable, and, therefore, financially burdensome costs of medical services through a comprehensive government-wide program of insurance for Federal employees ..., the costs of which will be shared by the Government, as employer, and its employees." H.R. Rep. No. 86-957 (1959), *reprinted in* 1959 U.S.C.C.A.N. 2913, 2914. Congress intended FEHBA to improve "the competitive position of the Government with respect to private enterprise in the recruitment and retention of competent civilian personnel" by providing federal employee health benefits similar to those available in the private sector. *See id.*

To implement this federal health benefit program, Congress empowered OPM to promulgate "regulations necessary to" effectuate FEHBA's statutory requirements. *See* 5 U.S.C. § 8913(a); *see*

also Mistretta v. United States, 488 U.S. 361, 373-74 (1989) (upholding Congress's authority to delegate power under broad general directives). OPM exercised its regulatory authority by promulgating extensive and comprehensive regulations. *See, e.g.*, 5 C.F.R. §§ 890.101 – 890.1308 (Federal Employees Health Benefits Program); 48 C.F.R. §§ 1601.101 – 1699.70 (Office of Personnel Management Federal Employees Health Benefits Acquisition Regulation).

The OPM regulations set forth in elaborate detail FEHBA's administrative requirements, including the procedure for review of enrollment and benefit determinations, available causes of action, and remedies. *See* 5 C.F.R. §§ 890.104 – 890.107. These regulations have the preemptive force of federal law. *See Fid. Fed. Sav. & Loan Ass'n v. de la Cuesta*, 458 U.S. 141, 153 (1982) ("Federal regulations have no less pre-emptive effect than federal statutes."); *see also Geier v. Am. Honda Motor Co.*, 529 U.S. 861, 872 (2000) (allowing "common-law actions that 'actually conflict' with federal regulations" would thwart "congressionally mandated objectives that the Constitution, through the operation of ordinary preemption principles, seeks to protect"). Moreover, since OPM was acting pursuant to a congressional delegation of authority, in an area where Congress alone had authority to act, the remedial scheme created by OPM should be deemed exclusive.

B. The FEHBA Statutory Provisions And Related Regulations Establish A Clear Framework For Operation Of A Tripartite Contractual Relationship.

To implement FEHBA, Congress authorized OPM to enter into federal procurement contracts with qualified "carriers" to offer health benefit plans to federal employees. *See* 5 U.S.C. § 8902(a) (power to contract). A "health benefits plan" is defined as a "group insurance policy or contract ... provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services." *Id.* § 8901(6). A "'carrier' means a voluntary association, corporation, partnership, or other nongovernmental organization ... engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts ...." *Id.* § 8901(7). OPM further established minimum standards carriers must satisfy to participate in the FEHBA program. *See* 48 C.F.R. § 1609.7001. In practice, OPM "enters into contracts with a handful of major insurance carriers." *Empire*, 547 U.S. at 702 (Breyer, J., dissenting). The fact that Congress designed the FEHBA program with OPM entering into contracts with carriers, as opposed to individual federal employees contracting with carriers, is important, because this structure allows OPM to retain control over the federal health benefits program.

Congress not only dictated who OPM could contract with, but also specified the types of health benefit plans that carriers can offer, including

service benefit plans, indemnity benefit plans, employee organization plans, and certain comprehensive medical plans. *See* 5 U.S.C. §§ 8903, 8903a. Unlike traditional insurance arrangements regulated by state law, federal employees must select from plans approved by OPM and offered by carriers contracted with OPM. *See* 5 U.S.C. § 8905(a) (allowing federal employees to enroll in approved health benefit plans); § 8907 (requiring OPM to provide individuals with sufficient information to "exercise an informed choice among the types of plans" offered).

Unlike traditional insurance contracts, the terms of the standard contracts between OPM and the carrier are largely dictated by federal law. *See, e.g.*, 5 U.S.C. § 8902(d), (j). FEHBA, for example, requires each OPM/carrier contract to include "a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as [OPM] deems necessary or desirable." *See id.* § 8902(d). FEHBA also authorizes OPM to prescribe reasonable minimum standards for health benefit plans offered by carriers. *See id.* § 8902(e); *see also* 5 C.F.R. § 890.201 (minimum standards for health benefit plans).

Congress further directed the inclusion of various contract provisions focusing on plan costs. The OPM/carrier contract, for example, must require carriers to undertake certain cost-containment measures in an effort to reduce benefit expenditures. *See* 5 U.S.C. § 8902(n). Additionally, each contract

must require the carrier to furnish reports to OPM and subject carriers to periodic audit by OPM. *See id.* § 8910.[3] FEHBA even governs the rates that can be charged for health benefit plans and mandates that rates "reasonably and equitably reflect the cost of the benefits provided." *See id.* § 8902(i).

FEHBA further requires that every OPM/carrier contract contain a provision requiring the carrier "to pay for or provide a health service or supply in an individual case" if OPM determines the employee is entitled to benefits. *See* 5 U.S.C. § 8902(j). This provision resulted from a FEHBA amendment enacted by Congress in 1974. The amendment gave OPM the power to compel a carrier to pay benefits when OPM resolved a dispute in favor of the federal employee. *See Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 396 (9th Cir. 2002). The amendment's legislative history suggests Congress intended to provide an administrative remedy for FEHBA disputes, without resort to the courts. *See id.*[4] Moreover, OPM's authority to determine what benefits must be paid further differentiates OPM/carrier contracts from traditional state-regulated insurance policies.

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[3] The OPM Office of Inspector General conducts those audits and furnishes Congress with semi-annual reports summarizing its findings. *See* 5 U.S.C. App. 3, §§ 4(a)(1), 5.

[4] See H.R. Rep. No. 93-459, at 2-3 (1973) (describing the amendment as making "all final determinations by the Commission on claim disputes ... binding upon the carrier involved"); *id.* at 7 (stating that the amendment was designed to change the current law, which "forced [an employee with a meritorious claim] into the courts if he is to recover his judgment").

The congressional decision to empower OPM to determine the right of federal employees to receive benefits is understandable, in part, because federal employee health benefits generally are paid from a government fund, not from a carrier's own funds. The FEHBA program is largely funded by a substantial federal government contribution, supplemented by employee payroll deductions. *See* 5 U.S.C. § 8906. The federal government pays approximately 75% of the plan "premiums" and the enrollee pays the rest. *See id.* § 8906(b). Unlike traditional insurance contracts, however, the contributions are not paid to the insurer. The contributions are paid into a dedicated Employees Health Benefits Fund maintained in the United States Treasury and administered solely by OPM. *See id.* § 8909(a). Carriers typically draw money from the fund to pay covered health care expenses. *See id.*; 48 C.F.R. § 1632.170. The money in the fund belongs to OPM—not the carrier. *See Empire*, 547 U.S. at 703 (Breyer, J., dissenting). The standard form contract also makes clear that the carrier will administer the plan in exchange for an adjustable service fee, which shall be the carrier's "total profit" under the contract. *See* J.A. 57 (CS 1039, § 3.7(a)).

Ordinarily, a carrier is not at risk when providing health plan benefits to federal employees. *See Empire*, 547 U.S. at 703 (Breyer, J., dissenting). "Rather, it earns a profit, not from any difference between plan premiums and the cost of benefits, but from a negotiated service charge that the federal agency pays directly." *Id.* Thus, the "carrier's only

role in this scheme is to administer the health benefits plan for the federal agency in exchange for a fixed service charge." *Id.* at 704. A carrier participating in a FEHBA plan, therefore, functions more like a third-party administrator than a traditional insurer.

In addition to the congressionally mandated statutory requirements, OPM established extensive regulations governing FEHBA contract provisions, including the precise language that must be included in various OPM/carrier contract clauses. *See* 48 C.F.R. §§ 1652.000 – 1652.370. Moreover, every OPM/carrier contract incorporates the entire FEHBA statute and all FEHBA regulations by specific reference. *See, e.g.*, Court of Appeals App., at A49 (CS 1039, § 1.4(a)).[5] The express incorporation of the FEHBA statute and regulations into the standard form contract confirms that the statute and regulations were intended to govern the relationship between OPM, the carrier, and enrolled federal employees. *See Miller v. United States*, 233 U.S. 1, 15 (1914) (giving effect to federal regulation incorporated by reference in government contract); *Hercules Inc. v. United States*, 292 F.3d 1378, 1381

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[5] Section 1.4(a) of Contract No. CS 1039 was not included in the joint appendix. Section 1.4(a) provides as follows:

> The applicable provisions of (1) chapter 89 of title 5, United States Code; (2) OPM's regulations as contained in part 890 of title 5, Code of Federal Regulations; and (3) chapters 1 and 16 of title 48, Code of Federal Regulations constitute a part of this contract as if fully set forth herein, and the other provisions of this contract shall be construed so as to comply therewith.

(Fed. Cir. 2002) (federal acquisition regulations incorporated into government contract are controlling).

Indeed, the standard form contracts not only bind OPM and the carriers, but also bind any enrolled federal employees. Each standard form contract provides that "[b]y enrolling or accepting services under this contract, [enrollees] are obligated to all terms, conditions, and provisions of this contract." *See* J.A. 36 (CS 1039, § 2.3(a)).

C. Federal Law Governs Federal Employee Eligibility And Enrollment In Federal Employee Health Benefit Plans.

Instead of entering into individual contracts for health insurance with an insurer, a federal employee enrolls in a FEHBA plan by submitting appropriate forms to their employing federal agency. *See* 5 U.S.C. § 8905(a); 5 C.F.R. §§ 890.102, 890.301. FEHBA specifies the individuals eligible to enroll in federal health care benefit plans. *See* 5 U.S.C. § 8901(1) (defining employee); § 8901(5) (defining member of family); § 8905 (election of coverage); § 8905a (continued coverage); § 8906a (temporary employees); § 8908 (restored employees and survivor or disability annuitants). An employee may enroll in a plan either as an individual or for "self and family." *See* 5 U.S.C. § 8905(a). Coverage for "self and family" generally is limited to the employee and the employee's spouse (or former spouse) and unmarried dependent children who are under 22

years of age or incapable of self-support because of a mental or physical disability which existed before age 22. *See id.* §§ 8901(5), 8905(a). Thus, the question of whether a federal employee is eligible to enroll in a FEHBA plan is purely a question of federal law.

Congress vested OPM with authority to promulgate regulations that "shall provide for the beginning and ending dates of coverage of employees, annuitants, members of their families, and former spouses under health benefits plans." *See* 5 U.S.C. § 8913(c). The OPM regulations provide that each employee is eligible to be enrolled in a health benefits plan "at the time and under the conditions prescribed" in the regulations. *See* 5 C.F.R. § 890.102(a). Moreover, OPM has discretionary authority to include and exclude certain classes of employees for purposes of FEHBA plan coverage. *See id.* § 890.102(e) ("[OPM] makes the final determination of the applicability of this section to specific employees or groups of employees.").[6]

The regulations further define the actions affecting an individual's FEHBA plan coverage – *i.e.*, "enroll," "change the enrollment," and "cancel" – as taking place at the specific direction of an agency

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[6] OPM, for example, recently promulgated a regulation extending FEHBA enrollment eligibility to former federal employees that accepted employment with a private corporation as part of the privatization of a former division of the Department of Defense. *See* 74 Fed. Reg. 66,565, 66,567 (Dec. 16, 2009) (to be codified at 5 C.F.R. § 890.111).

employing office, following submission to that office of the appropriate supporting documentation. *See* 5 C.F.R. § 890.101(a). The regulations define "employing office" as "the office of an agency to which *jurisdiction and responsibility* for health benefits actions for an employee ... have been delegated." *See id.* (emphasis added). "Enroll" means "to submit to the employing office an appropriate request electing to be enrolled in a health benefit plan." *See id.* "Enrolled" means "an appropriate request has been accepted by the employing office and the enrollment in a health benefits plan approved by OPM." *See id.* Accordingly, the regulations clearly establish that federal authorities, not carriers, have the sole and exclusive responsibility for enrollment decisions.

The standard form contract specifically conditions both eligibility for enrollment and termination of enrollment on the OPM regulations and directs the employing office "having cognizance over the Enrollee" to "promptly furnish notification" to carriers of individual enrollment decisions. *See, e.g.*, J.A. 33-34, 42 (CS 1039, §§ 2.1(a), 2.4). Moreover, on a quarterly basis, each employing office must report to each carrier the names of all individuals enrolled in the carrier's plan. *See* 5 C.F.R. § 890.110 (enrollment reconciliation). Neither FEHBA, nor the OPM regulations, nor the standard contract terms, authorizes carriers to enroll federal employees or alter the enrollment status of federal employees. Instead, carriers are provided enrollment information by the employing offices

responsible for making enrollment decisions. *See* J.A. 33 (CS 1039, § 2.1(a)(1)).

D. Federal Law Provides The Exclusive Cause of Action For Enrollment And Benefit Disputes Arising Under A Federal Employee Health Benefit Plan.

Although FEHBA does not specify a procedure for dispute resolution, Congress vested OPM with the power to promulgate necessary regulations. *See* 5 U.S.C. § 8913(a); *see also Household Credit Servs., Inc. v. Pfennig*, 541 U.S. 232, 239 (2004) ("[W]henever Congress has 'explicitly left a gap for the agency to fill,' the agency's regulation is 'given controlling weight unless [it is] arbitrary, capricious, or manifestly contrary to the statute.'" (quoting *Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 843-44 (1984))). The OPM, therefore, properly promulgated regulations creating a detailed and comprehensive remedial scheme to resolve disputes concerning enrollment and benefits. *See* 5 C.F.R. §§ 890.104 – 890.107. In fact, the standard form contracts explicitly set forth the administrative procedures and remedies established under the regulations for resolving such disputes. *See* 48 C.F.R. § 1652.204-72 (mandatory contract clause setting forth federal regulatory scheme for resolving enrollment and benefit disputes, including administrative procedures, remedies, and judicial review); *see also, e.g.*, J.A. 43-49 (CS 1039, § 2.8).

1. Enrollment Disputes Are To Be Resolved By The Employing Federal Agency.

The regulations pertaining to enrollment disputes authorize the employing office to make prospective and retroactive corrections of administrative errors. *See* 5 C.F.R. § 890.103(a). Specifically, the regulations permit employing offices to correct enrollment errors on a prospective basis at any time, *see id.* § 890.103(a), and retroactively upon an individual's timely reporting of the error, *see id.* § 890.103(c). Additionally, the regulations permit OPM to correct administrative enrollment errors when "equity and good conscience" demand. *See id.* § 890.103(b).

The regulations further establish a detailed administrative review procedure by which federal employees can seek reconsideration of an agency employing office's initial decision "denying coverage or change of enrollment." *See* 5 C.F.R. § 890.104. A federal employee initiates the administrative review procedure by filing a timely written request for reconsideration with the employing office that made the initial enrollment decision. *See id.* § 890.104(a) – (d). The employing office must conduct an independent review "designated at or above the level at which the initial decision was rendered." *See id.* § 890.104(c)(2). After reconsideration, the employing office must issue a written final decision fully setting forth its findings and conclusions. *See id.* § 890.104(e).

If a federal employee is dissatisfied with the employing office's decision after reconsideration, then the employee may seek judicial review. *See* 5 C.F.R. § 890.107(a). "A suit to compel enrollment under § 890.102 must be brought against the employing office that made the enrollment decision." *Id.* § 890.107(a). Indeed, the standard FEHBA contract sets forth verbatim the text of § 890.107(a) mandating that actions to compel enrollment be filed against the employing office making the enrollment decision. *See, e.g.*, J.A. 48 (CS 1039, § 2.8(g)). Accordingly, a lawsuit to compel enrollment under a FEHBA plan cannot be brought against a carrier, but must be filed against the appropriate employing office. *See id.* Since the employing office is always an agency of the United States, jurisdiction is proper in the federal courts. *See* 5 U.S.C. § 8912 (providing federal jurisdiction over civil actions or claims against the United States arising under FEHBA); 28 U.S.C. § 1442(a)(1) (providing for removal of civil actions brought against the United States or an agency thereof); *see also City of Cookeville v. Upper Cumberland Elec. Membership Corp.*, 484 F.3d 380, 390 (6th Cir. 2007) (holding § 1442(a)(1), as amended in 1996, expressly permits federal agency to remove civil action to federal court).

In sum, FEHBA contemplates no role for carriers in (i) enrollment decisions, (ii) correction of enrollment errors, (iii) reconsideration of enrollment decisions, or (iv) lawsuits to compel enrollment. Rather, the regulations set forth both administrative and judicial review procedures for the resolution of enrollment disputes. If, after pursuing an

administrative appeal, the employee is dissatisfied with the decision of the employing agency, then the exclusive cause of action is to seek judicial review by initiating an action to compel enrollment against the employing agency.

2. Benefit Disputes Are To Be Resolved By OPM.

The OPM regulations also establish a detailed and comprehensive administrative remedy for resolving benefit disputes. *See* 5 C.F.R. §§ 890.105, 890.107(c) – (d). Health claims are initially submitted to the carrier and the carrier makes the initial benefit decision. *See id.* § 890.105(a)(1). If the carrier denies the claim, then a federal employee may ask the carrier to reconsider. *See id.* If the carrier affirms the denial or fails to timely respond to the request for reconsideration, then the federal employee may ask OPM to review the claim. *See id.* The regulations also establish time limits and other requirements for requesting reconsideration, time limits for a carrier and OPM to render their respective decisions, and the duties and responsibilities of a carrier and OPM when conducting an administrative review. *See id.* § 890.105. Significantly, federal employees "must exhaust both the carrier and OPM review processes specified in [§ 890.105] before seeking judicial review." *See id.* § 890.105(a)(1); *see also* § 890.107(d)(1).

Once the administrative review process has been exhausted, a federal employee can seek judicial

review of OPM's final benefit decision. *See* 5 C.F.R. § 890.107(c). A claim seeking judicial review of the final benefit decision "must be brought against OPM and not against the carrier or the carrier's subcontractors." *See id.* Moreover, the recovery in such a case "shall be limited to a court order directing OPM to require the carrier to pay the amount of benefits in dispute." *See id.*; *see also* 5 U.S.C. § 8902(j) (requiring carrier to provide health benefit if OPM directs carrier to pay the claim). Notably, the evidence on judicial review is "limited to the record that was before OPM when it rendered its decision affirming the carrier's denial of benefits." *See* 5 C.F.R. § 890.107(d)(3).

As this Court has recognized, § 890.107(c) "channels disputes over coverage or benefits into federal court by designating a United States agency (OPM) sole defendant." *See Empire*, 547 U.S. at 686-87; *see also Empire HealthChoice Assurance, Inc. v. McVeigh*, 396 F.3d 136, 145 n.7 (2d Cir. 2005) (Sotomayor, J.). Indeed, the regulations adopted by OPM explicitly prohibit a claim against a carrier to recover health care benefits. *See Botsford*, 314 F.3d at 398 (holding remedies available under OPM's regulatory scheme are the "only intended remedies" under FEHBA).

At one time, OPM regulations required any lawsuit challenging a final OPM benefit decision be initiated against the carrier, not OPM. *See, e.g., Harris v. Mut. of Omaha Cos.*, 992 F.2d 706, 712 (7th Cir. 1993). In 1995, however, OPM issued interim regulations changing this requirement. The interim

regulations required any legal action arising from the denial of federal health benefits be brought against OPM, not a carrier rendering an initial benefit decision. *See* 60 Fed. Reg. 16,037 (Mar. 29, 1995) (interim regulations). In discussing the interim regulations, OPM clarified that the administrative review process established by the regulations "must be followed before legal action is pursued in the courts;" "the matter to be reviewed by a court upon appeal is the OPM decision affirming the carrier's denial of benefits;" and the court's review is "limited to an examination of OPM's administrative decision to deny the claim for payment or services." *See id.*[7]

On May 6, 1996, the interim regulations, with minor revisions, became final. *See* 61 Fed. Reg. 15,177 (May 6, 1996) (final regulations). In a discussion concerning the final regulations, OPM explained how the regulations were modified "to specify that court action is not to be brought against the carrier or the carrier's subcontractors." *See id.* "Since it is OPM's decision, not the carrier's, that is being contested, it is appropriate that OPM, rather than the carriers, be the focus of lawsuits related to denial of benefits." *Id.* OPM further stated that, with respect to benefit disputes, its regulations never offered covered individuals a right of access to state courts, the right to seek monetary damages, or

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[7] An agency's interpretation of its own regulation is entitled to judicial deference. *See Auer v. Robbins*, 519 U.S. 452, 461 (1997) (holding Secretary of Labor's interpretation of own regulation is "controlling unless plainly erroneous or inconsistent with the regulation") (internal quotations omitted).

the right to initiate a lawsuit without first seeking OPM review. *See id.* at 15,177-178. In OPM's view, such actions "are not available to covered individuals under the FEHB program" given the express preemption provision in the statute. *See id.* at 15,178.[8]

3. FEHBA's Express Preemption Provision.

The FEHBA preemption provision was first enacted by Congress in 1977. The U.S. Civil Service Commission ("CSC"),[9] the predecessor to OPM, urged Congress to "establish uniformity of benefits and coverage" by enacting a preemption clause. *See* H.R. Rep. No. 95-282, at 6 (1977). In 1975, a Comptroller General report observed that states were becoming increasingly active in enacting and enforcing health insurance laws that conflicted with the terms of the contracts CSC was entering into under FEHBA, and expressed concern that this trend would lead to increased premium costs and "[a] lack of uniformity of benefits for all enrollees in the same health plan, since enrollees in some states would be paying a premium based, in part, on the

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[8] "[C]onsiderable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer ...." *Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.* 467 U.S. 837, 844 (1984) (footnote omitted).

[9] The CSC was the federal agency then serving as the FEHBA program administrator. Pursuant to the Civil Service Reform Act of 1978, Pub. L. 95-454, the CSC was abolished effective January 1, 1979. Responsibility for fulfilling the CSC's various governmental functions was distributed among several agencies, including the newly created OPM.

cost of benefits provided only to enrollees in other states." *See* S. Rep. No. 95-903, at 9 (1978). The Comptroller General, therefore, recommended that Congress "consider legislation to clarify whether state requirements should be permitted to alter terms of contracts negotiated pursuant to [FEHBA]." *See id.* In response to that recommendation, Congress proposed legislation "to establish uniformity in benefits and coverage under the [FEHBA] program." H.R. Rep. No. 95-282, at 1. Commenting on that proposed legislation, the CSC adopted the following legal opinion of its general counsel:

> [T]he supremacy clause creates an immunity from State interference of Federal operations. The principle underlying the need for national uniformity in the administration of Federal functions operate to supersede conflicts arising from State laws and apply with equal regard to the [CSC]'s administration of the [FEHBA] ... If the [CSC] is to have the free hand it needs to administer the [FEHBA], no other conclusion can be reached.

Id. at 7.

Notwithstanding CSC's views, FEHBA's original preemption clause was somewhat narrower in scope than the current provision. The prior provision preempted state and local laws and regulations that were "inconsistent with" the contractual provisions of FEHBA plans. *See* 5

U.S.C. § 8902(m)(1) (1997) (amended 1998). After some courts rejected complete preemption based on the "inconsistent with" language in the original preemption clause,[10] Congress broadened the provision in 1998 by deleting the phrase "to the extent that such law or regulation is inconsistent with such contractual provisions." *See Botsford*, 314 F.3d at 393.

The FEHBA preemption clause now reads as follows:

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1).[11] The legislative history relating to the 1998 amendment confirms the intent of Congress "that FEHB program contract terms which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) completely displace State or local law relating to health insurance or plans." *See* H.R. Rep. No. 105-374, at 16 (1997). Accordingly, based on the

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[10] *See Rievley v. Blue Cross Blue Shield of Tenn.*, 69 F. Supp. 2d 1028, 1033 (E.D. Tenn. 1999) (collecting cases).

[11] Although some courts have found the FEHBA preemption clause similar to the ERISA preemption clause, *see Botsford*, 314 F.3d at 393-94, the FEHBA preemption provision contains no "savings clause," and federal employee benefits is an area over which Congress has exclusive constitutional authority.

FEHBA preemption clause as it now reads, "state law—whether consistent or inconsistent with federal plan provisions—is displaced on matters of 'coverage or benefits.'" *Empire*, 547 U.S. at 686. Thus, the purpose of the preemption clause—to "ensure uniform coverage and benefits under plans OPM negotiates for federal employees"—was advanced by the 1998 amendment. *See id.*

Since the FEHBA preemption provision was amended, nearly every reported decision holds state law claims relating to benefit disputes are completely preempted. *See Botsford*, 314 F.3d at 399 (state unfair trade practice claim completely preempted); *St. Mary's Hosp. v. Carefirst of Md.*, 192 F. Supp. 2d 384, 390 (D. Md. 2002) (provider's contract claims against carrier completely preempted); *Rievley v. Blue Cross Blue Shield of Tenn.*, 69 F. Supp. 2d 1028, 1037 (E.D. Tenn. 1999) (breach of contract, breach of fiduciary duty, and claim for bad faith denial of insurance benefits completely preempted); *Carter v. Blue Cross & Blue Shield of Fla., Inc.*, 61 F. Supp. 2d 1237, 1241 (N.D. Fla. 1999) (contract claim completely preempted); *Kight v. Kaiser Found. Health Plan of the Mid-Atl. States, Inc.*, 34 F. Supp. 2d 334, 342 (E.D. Va. 1999) (tortious interference of contract, fraud, and negligent failure to establish guidelines and procedures completely preempted). *But see Ramirez v. Humana, Inc.*, 119 F. Supp. 2d 1307, 1313 (M.D. Fla. 2000) (no complete preemption for various state law claims arising from alleged wrongful denial of benefits). This Court is called upon to definitively determine that federal employee health care

coverage and benefit disputes are subject to complete preemption and removable to federal court.

II. PERMITTING RESPONDENTS TO PROCEED IN STATE COURT WOULD UNDERMINE FEHBA.

If this Court were to hold that the federal cause of action for federal employees seeking coverage and benefits under an OPM contract is not exclusive, then it is a near certainty no state court will reach a different result. In fact, the predictable initial result of such a holding would be state-by-state litigation associated with adjudicating claims by federal employees against carriers under contract with OPM. The cost of such litigation likely would be passed along to the federal government and federal employees in the form of higher administrative costs.

Another problem with not finding the federal remedy exclusive would be the likely patchwork of state court decisions directing administration and operation of FEHBA plans according to unique and varying interpretations of respective state law requirements. This, in turn, would devolve the current national and uniform administration of federal employee benefits by OPM into a state-by-state *ad hoc* benefit system. The additional administrative costs associated with this change in the FEHBA program likewise would be passed along to the federal government and federal employees. Given the already significant cost of health care in the United States, adding further administrative costs to the FEHBA program may push the cost of

health care beyond the reach of some federal employees. *See* Organization for Economic Co-Operation and Development, *Health Expenditure in Relation to GDP* in *Health at a Glance 2009: OECD Indicators* (2009), *available at* http:// www.oecdilibrary.org/oecd/sites/health_glance – 2009 - en /07/03/g7-02-01.html (finding health care costs were 16.0% of GDP in the United States, compared to 10.1% in Canada, 8.4% in United Kingdom, and 8.9% on average for OECD states); J. Davidson, *Health Coverage Not Universal for Federal Workforce*, Washington Post, Sept. 18, 2009, at A23 (discussing inability of federal employees to afford health insurance and identifying rising health insurance costs and cap on government portion of premium as factors).

The tripartite relationship Congress established in FEHBA, with OPM contracting with the carriers, and the employees receiving benefits through the carriers, was not designed to operate on a state-by-state basis. Rather, the clear congressional intention was to have OPM administer a uniform federal program for the benefit of all federal employees.

Although any one federal employee may view their rights as best vindicated in state court under state law, from a national perspective, the remedial scheme implemented by OPM's regulations strikes an appropriate balance and makes the party responsible for rendering the relevant decision amenable to a lawsuit. Conversely, the lawsuit initiated in this action sought to compel the carrier

to violate federal law (or risk contempt) by requiring the carrier to enroll an individual in a FEHBA plan, when, at the time the complaint was filed, the employing federal agency had reached the opposite decision.

Moreover, if the federal remedial scheme were determined not to be exclusive, then the administrative remedial process may be cast aside whenever a federal employee concludes their interests are paramount to the systemic benefit of having enrollment and benefit issues first resolved by the employing agency or OPM. Although in any individual instance a federal employee might be able to argue her interests are better served in a different forum, no legitimate argument can be made that the comprehensive administrative and judicial procedures established by OPM, within the confines of the tripartite relationship directed by Congress, are either unfair or unreasonable.

The administrative procedures established by OPM with respect to enrollment and benefit decisions are designed to correct errors without resorting to costly litigation. If this Court were to determine the federal remedial scheme is not exclusive, then the administrative process and its attendant cost savings will be negated. Instead, federal employees will be able to compel carriers to incur significant litigation costs when, as apparently was the case here, a short administrative complaint would have resolved the issue without the need for any party to initiate litigation. *See* J.A. 97-98.

In sum, any one individual can claim a particular state law or process is most beneficial to her. The Court, however, should consider this issue from a national systemic perspective. From that perspective, the system is designed for the good of all federal employees and can operate as intended only if the Court concludes federal law provides the exclusive cause of action for federal employees seeking coverage or benefits under an OPM/carrier contract.

CONCLUSION

For the foregoing reasons, the judgment of the United States Court of Appeals for the Seventh Circuit should be reversed.

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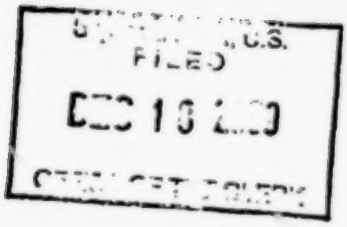
AMICUS CURIAE BRIEF



No. 09-38

IN THE

Supreme Court of the United States

HEALTH CARE SERVICE CORPORATION,
Petitioner,

v.

JULI A. POLLITT and MICHAEL A. NASH,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF OF ALLIANCE OF COMMUNITY HEALTH PLANS AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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QUESTIONS PRESENTED

1. Whether the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-14, completely preempts – and therefore makes removable to federal court – a state court suit challenging enrollment and health benefit determinations that are subject to the exclusively federal remedial scheme established in FEHBA.

2. Whether the federal officer removal statute, 28 U.S.C. § 1442(a)(1), which authorizes federal removal jurisdiction over state court suits brought against persons "acting under" a federal officer when sued for actions "under color of [federal] . . . office," encompasses a suit against a government contractor administering a FEHBA plan, where the contractor is sued for actions taken pursuant to the government contract.

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INTEREST OF AMICUS CURIAE

Amicus curiae[1] is the Alliance of Community Health Plans ("ACHP"),[2] an association of non-profit, community-based and regional health plans and provider organizations that are dedicated to delivering patient-centered care of the highest quality and value. ACHP submits this *amicus* brief because the Seventh Circuit's opinion in *Pollitt v. Health Care Service Corp.* will adversely impact its non-profit community and regional health plan members and their ability to provide cost-effective

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[1] This amicus brief is filed with the consent of the parties, in accordance with this Court's Rule 37.3(a). In a letter to the Court on December 11, 2009, Respondents provided blanket consent to the filing of amicus briefs. On December 14, 2009, Petitioner filed a letter providing blanket consent to the filing of amicus briefs. Pursuant to Rule 37.6, no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus curiae,* its members, or its counsel made a monetary contribution to its preparation or submission.

[2] ACHP members participating in FEHBP include: Capital District Physicians Health Plan (NY), Capital Health Plan (FL), ConnectiCare (subsidiary of Health Insurance Plan of Greater New York), Fallon Community Health Plan (MA), Geisinger Health Plan (PA), Group Health Cooperative (WA), Group Health Cooperative of South Central Wisconsin (WI), Health Insurance Plan of Greater New York (EmblemHealth), HealthPartners (MN), Independent Health Plan (NY), Kaiser Foundation Health Plan, Presbyterian Health Plan (NM), and UPMC Health Plan (PA).

high quality health services and benefits to their Federal Employee Health Benefits Program ("FEHBP") enrollees. Like Petitioner, ACHP's members furnish health care plan services for federal employees pursuant to Federal Employee Health Benefits Act ("FEHBA"); although, unlike Petitioner, their services are provided under the FEHBA through comprehensive prepaid medical plans under 5 U.S.C. § 8903(4). Most of them contract with the Office of Personnel Management ("OPM") to provide benefits under the FEHBP on a community rated basis. *See* 48 C.F.R. § 1602.170-2.

The FEHBA's federal remedial scheme provides for the judicial review of OPM's and the carrier's administrative decisions *only* in federal court against the OPM. The Seventh Circuit's opinion, if upheld, will result in significant litigation brought against ACHP's members by opening state courts to FEHBA litigation, which properly belongs in federal court. Enrollees in FEHBP – a program covering millions of federal employees – will be able to evade the federal remedial scheme simply by suing the wrong party – such as one of ACHP's members – in state court, rather than suing the proper party – the OPM – in federal court.

INTRODUCTION AND SUMMARY OF ARGUMENT

In *Pollitt v. Health Care Service Corporation*, 558 F.3d 615 (7th Cir. 2009), the Seventh Circuit Court of Appeals rejected Petitioner's argument that Respondents' FEHBA claims are completely preempted by federal law and therefore removable.

It also applied an incorrect and unsupported standard for federal officer removal jurisdiction. In denying FEHBA benefits-related claims their proper place in federal court, the Seventh Circuit has created an anomaly in federal health benefits law. Through either complete preemption or federal officer removal principles, plans defending against claims for health coverage or benefits provided in all three other major national health benefit arenas – ERISA, Medicare, and TRICARE – can follow a path to federal court, through removal of claims filed first in state court.

This Court has previously ruled that section 502(a)(1)(B) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), provides federal jurisdiction over "'causes of action within the scope of the civil enforcement provision of § 502(a)'" and that such claims can be removed. *Aetna v. Davila,* 542 U.S. 200, 209 (2004) (*citing Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987)). Likewise, federal courts have held that under 28 U.S.C. § 1442(a)(1), the federal officer removal statute, Medicare, CHAMPUS, and TRICARE claims related to the administration of benefits are removable. The law warrants consistency, and there is, moreover, no policy reason to apply a different standard to FEHBA than applies to ERISA, Medicare and TRICARE. It would be anomalous indeed if suits against plans serving federal employees could be brought in state court without removal authority, while state court claims against private health plans are subject to removal to federal court under ERISA.

The law does not require such a result, and indeed demands the opposite.

For the same reasons claims related to other federal health benefit statutes are subject to removal and entitled to federal jurisdiction, so should FEHBA claims be found subject to federal jurisdiction and removal. If Respondents are allowed to evade the federal remedial scheme and pursue FEHBA benefit and enrollment claims in state court, enrollees in the FEHBP, which covers millions of federal employees, will be permitted to evade the mandatory federal administrative remedy pathway simply by suing the wrong party in state court to avoid removal.

Claims brought in state court challenging FEHBP enrollment and health benefit determinations should be removable to federal court pursuant to complete preemption and/or the federal officer removal statute, 28 U.S.C. 1442(a)(1).

ARGUMENT

I. THE SEVENTH CIRCUIT'S OPINION, IF UPHELD, WILL ADVERSELY IMPACT HEALTH CARE PLANS ADMINISTERING FEHBA HEALTH CARE BENEFIT CONTRACTS

A. The Seventh Circuit's Opinion Adversely Impacts ACHP Members.

Amicus curiae is the Alliance of Community Health Plans ("ACHP"), an organization of prepaid health care plans owned or operated by non-profit entities, who deliver affordable, high-quality

coverage and care to voluntarily enrolled members in more than 20 states and the District of Columbia. ACHP members are consistently among the highest-performing health plans in the nation. ACHP's stated mission is to "improve the health of the communities we serve and actively lead the transformation of health care so that it is safe, effective, patient-centered, timely, efficient and equitable." In achieving this mission, ACHP advocates for better health care, and works to solve the health care challenges facing its members.

ACHP's members are predominantly not-for-profit charitable or social welfare organizations exempt from federal taxation under Sections 501(c)(3) or 501(c)(4) of the Internal Revenue Code of 1986, as amended. These health plans enroll some 18 million individuals nationwide including approximately 600,000 enrollees under the FEHBP. They contract with the federal Office of Personnel Management ("OPM") under the FEHBP as comprehensive health plans, most doing so on a community rated basis. Some member plans have offered an FEHBP option for more than 30 years.

ACHP member plans have a strong and stable presence in the communities they serve and earn the loyalty of their enrollees; many of the health plans offered by ACHP members have retention rates of 90 percent or more. Whether they are organized as fully integrated delivery systems or through contracted networks, ACHP member health plans set standards for selecting providers and work closely with providers to coordinate care, ensure

appropriate utilization of services, and meet goals for quality and affordability. Both the National Committee for Quality Assurance (NCQA) and the U.S. Centers for Medicare and Medicaid Services evaluate health plans on clinical quality, patient satisfaction, and related measures. Eleven of the top 25 commercial plans and 15 of the top 25 Medicare plans are ACHP member plans in the rankings based on the most recent NCQA evaluation.

ACHP submits this *amicus* brief because the Seventh Circuit's opinion in *Pollitt v. Health Care Service Corp.* will adversely impact its members and their provision of benefits to hundreds of thousands of FEHBP enrollees. The Seventh Circuit's opinion, if upheld, will open state courts to FEHBA litigation, resulting in disruption of the scheme contemplated by Congress for resolution of FEHBA enrollment and benefit disputes. It is insufficient protection for ACHP's member plans and the FEHBP itself to count on disparate state courts across the country to consistently and correctly dispose of improperly framed state law claims. It is particularly insufficient because Congress contemplated that a unitary federal standard would be applied in the federal courts following the prescribed administrative review process.

II. THE SEVENTH CIRCUIT'S RULING ALLOWS A PLAINTIFF TO EVADE FEHBA'S FEDERAL REMEDIAL SCHEME

The Petitioner, Health Care Service Corporation ("HCSC"), administers pursuant to a government contract the health care plan covering

Respondent and her son. Like HCSC, ACHP's members contract with OPM to provide plans offering health benefits to federal employees pursuant to FEHBA. Under the Seventh Circuit's ruling, ACHP members facing enrollee claims styled as arising under state law would be foreclosed from the federal courts. The Seventh Circuit's ruling, if upheld, will engender a surge in state court claims burdening ACHP members and risking disruption to the operation of the FEHBP.

Respondent Juli A. Pollitt receives health insurance as a benefit of her federal employment pursuant to the FEHBA. Respondents filed this lawsuit after HCSC ceased payments for claims submitted for Ms. Pollitt's son, Michael, and sought reimbursement from health care providers for the payments HCSC had made on Michael's behalf for the preceding four years. Respondents sued HCSC, the private party who administers the benefit plan, in state court. Respondents' original complaint asked that the Court "enter judgment . . . directing [HCSC] to honor all medical insurance claims for their minor child." J.A. 81. Similarly, the second amended complaint requested that HCSC halt any efforts to collect payments made previously on Respondents' son's behalf. *Id.* at 130. At bottom, the claims in Respondents' original complaint were based on "benefits and administration of FEHBA plans." *Pollitt v. HCSC*, No. 07 C 5961, 2008 WL 6928357, at *1 (N.D. Ill. Sept. 5, 2008). These claims are subject to the federal remedial scheme under the FEHBA and its implementing regulations.

Under FEHBA, the contracts entered into with each carrier shall "contain a detailed statement of benefits offered" and "shall require that the carrier . . . agree to pay for or provide a health service or supply . . . if the Office finds that the . . . person . . . is entitled thereto under the terms of the contract." 5 U.S.C. § 8902(d), (j). OPM has implemented through regulation a remedial scheme for individuals who believe the carrier improperly denied them benefits. *See* 5 C.F.R. § 890.105(a)(1).

FEHBA provides the exclusive enforcement mechanism for enrollment and benefit disputes brought by members of a federal employee health benefit plan. *See Id.* §§ 890.104(a); 890.107(a), (c). The regulations set forth a specific remedial scheme. *See Id.* § 890.105(a)(1). Benefit claims must first be submitted to the carrier of the health care plan. *Id.* If the claim is denied, the individual may seek reconsideration with the carrier. *Id.* If the carrier does not respond or "affirms its denial," the "covered individual may ask OPM to review the claim." *Id.* Only after the individual exhausts both the carrier's and OPM's "review processes," can the individual seek to have the decision reviewed in an action against OPM. *Id.* §§ 890.105(a)(1); 890.107(c).

The regulations prohibit the commencement of a lawsuit prior to the exhaustion of administrative remedies. *Id.* §§ 890.107(c); 890.105(a)(1). Moreover, the regulations require that a "legal action to review final action by OPM involving such denial of health benefits must be brought against OPM *and not against the carrier or carrier's*

subcontractors." *Id.* § 890.107(c) (emphasis added). Any lawsuit against OPM to review the administrative decision must commence in federal court. *See* 5 U.S.C. § 8912; *see also Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 696 (2006) (explaining that FEHBA's enforcement provisions "ensure that suits brought by the beneficiaries for denial of benefits *will land in federal court*") (citations omitted) (emphasis added).

In *Pollitt*, Respondents attempted to end run FEHBA's requirement that administrative remedies first be exhausted before review may be had in an action against OPM in federal court. Instead of adhering to this procedure, Respondents sued the HCSC in state court under state law. If the Seventh Circuit's ruling is upheld, enrollees in FEHBP will be allowed to evade the federal remedial scheme entirely, simply by suing the wrong party – *i.e.* the plan contractor rather than OPM – in state court.

The Seventh Circuit's opinion denied these benefit-related claims their proper place in federal court. In rejecting Petitioner's argument that these claims are completely preempted and in applying the incorrect standard for federal officer removal, the Seventh Circuit effectively closed the door to litigating these cases in federal court. With respect to complete preemption as a basis for removal, the Seventh Circuit relied on the wrong preemption standard and ignored this Court's most recent decision on complete preemption, *Beneficial Nat'l Bank v. Anderson*, 539 U.S. 1 (2003).

The Seventh Circuit also incorrectly concluded that federal officer removal is only proper if the federal agency "direct[ed]" the carrier to change Respondents' coverage. *Pollitt*, 558 F.3d at 616. The Seventh Circuit improperly focused on whether the agency specifically directed the action, instead of whether Petitioner's conduct stems from its obligations as a government contractor. *Id.* at 616-17. If the Seventh Circuit's improper federal officer removal standard is allowed to stand, it will severely depress the ability of FEHBA plan contractors to remove to federal court.

Moreover, permitting claimants to evade federal court "undermines" the intent of Congress to "achieve uniform administration of FEHBA plans." *Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 395 (9th Cir. 2002). Applying differing state standards to FEHBP-based claims, and different state court determinations regarding the applicability of state law to such claims, will "disrupt the nationally uniform administration" of FEHBA benefits, "increase administrative costs," and thereby increase the overall cost of federal health care. *Id.*

If the Seventh Circuit ruling stands, ACHP's members will face similar litigation in state courts. Enrollees or those seeking to pursue claims on their behalf will have an avenue to evade the carefully constructed FEHBP remedial scheme, and bring lawsuits against ACHP members, threatening their ability as non-profit community and regional health

plans to maintain their service levels in the program.

III. IF THE SEVENTH CIRCUIT RULING STANDS, FEHBA WILL BE THE ONLY SIGNIFICANT NATIONAL HEALTH BENEFITS REGIME WITHOUT A PATH FOR DEFENDANTS TO FEDERAL COURT

Through two separate removal schemes, numerous courts have concluded that claims related to the coverage or benefits provided under ERISA, Medicare, and TRICARE all have a path to federal court open to defendants. This Court has previously ruled that section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), provides complete preemption and, accordingly, that "causes of action within the scope of the civil enforcement provision of § 502(a)" can be removed to federal court. *Aetna v. Davila,* 542 U.S. 200, 210 (2004) (*citing Metropolitan Life,* 481 U.S. at 66). Likewise, numerous federal courts have held that under 28 U.S.C. § 1442(a)(1), the federal officer removal statute, Medicare, CHAMPUS, and TRICARE claims are subject to removal. The Seventh Circuit ruling would deny defendants facing FEHBA-based claims pertaining to the "nature, provision or extent of coverage or benefits" (5 U.S.C. § 8902(m)(1)) the same right of access to a federal court that similar benefit schemes provide, whenever the plaintiff styles their complaint as arising under state law. To restore logical parity, under either complete preemption or federal officer removal, claims relating to the "nature, provision or extent of

coverage or benefits" (5 U.S.C. § 8902(m)(1)) under FEHBA should be removable to federal court.

A. Complete Preemption Provides Federal Courts Jurisdiction Over Claims Relating To The Administration of FEHBP Benefits.

1. Complete Preemption

An action "arising under" federal law may be removed to federal court if the complaint "affirmatively allege[s] a federal claim." 28 U.S.C. § 1441(b); *Beneficial Nat'l Bank*, 539 U.S. at 6. In determining whether the complaint properly alleges a federal claim, courts apply the well-pleaded complaint rule. *Davila*, 542 U.S. at 207. The well-pleaded complaint rule instructs that whether a case arises under federal law "must be determined from what necessarily appears in the plaintiff's statement of his own claim in the bill or declaration, unaided by anything alleged in anticipation of avoidance of defenses which it is thought the defendant may interpose." *Id.* (citing *Taylor v. Anderson*, 234 U.S. 74, 75-76 (1914)).

A state claim can be removed, however, when "a federal statute wholly displaces the state-law cause of action through complete pre-emption." *Id.* The Court has found complete preemption when the cause of action, "even if pleaded in terms of state law, is in reality based on federal law." *Id.* Because the claim "aris[es] under" federal law, it meets the requirements of 28 U.S.C. § 1441(b) and is properly removable to federal court. *Beneficial Nat'l Bank*,

539 U.S. at 8. The Court has found complete preemption under three statutes for certain claims: (1) § 301 of the Labor Management Relations Act, 1947 ("LMRA"); (2) § 502(a) of ERISA; and (3) §§ 85 and 86 of the National Bank Act. *See Avco Corp. v. Machinists*, 390 U.S. 557 (1968) (LMRA); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987) (ERISA); *Beneficial Nat'l Bank*, 539 U.S. 1 (2003) (National Bank Act).

2. ERISA Complete Preemption

ERISA provides minimum standards that cover most voluntarily created private pension and health plans. The Court has held that § 502(a)(1)(B) of ERISA's statutory regime provides complete preemption. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987). In *Metropolitan Life*, the Court held that § 502(a)(1)(B) reflected an intent by Congress to "so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character." *Id.* at 63-64. Section 502(a)(1)(B) provides:

> (a) Persons empowered to bring a civil action. A civil action may be brought-- (1) by a participant or beneficiary-- (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

29 U.S.C. § 1132(a)(1)(B).

In 2004, the Court further addressed the scope of the complete preemption provided by Section 502(a)(1)(B). *Davila*, 542 U.S. at 210. In *Davila*, the plaintiffs were beneficiaries in ERISA-regulated employee benefit plans. *Id.* at 204. Plaintiffs sued their insurance carriers alleging they suffered injuries from the denial of coverage for certain treatments. *Id.* at 204-05. The Court held that the plaintiffs' claims, which would "remedy only the denial of benefits under ERISA-regulated benefits plans, fall within the scope of, and are completely pre-empted by, ERISA § 502(a)(1)(B), and thus removable to federal court." *Id.* at 221.

In *Davila*, the Court held that § 502(a)(1)(B) covers lawsuits for claims the beneficiary believes he or she is entitled to under the plan, but are not provided. *Id.* at 210. It also covers lawsuits to "generically . . 'enforce his rights' under the plan, or to clarify any of his rights to future benefits." *Id.* Accordingly, any cause of action that falls under § 502(a)(1)(B) is removable to federal court. *Id.* In interpreting § 502(a)(1)(B), the Court concluded that it covered any claim that "could have [been] brought . . . under 502(a)(1)(B) . . . where there is no other independent legal duty that is implicated by a defendant's action." *Id.*

3. FEHBA

a. FEHBA's Unitary Federal Scheme for Review of Claim Denial Disputes Supports Complete Preemption

Numerous courts have concluded that FEHBA's remedy for the denial of benefits completely preempts state law claims based on benefits grievances. *See e.g., Botsford,* 314 F.3d at 399; *BlueCross BlueShield of Tenn., Inc. v. Griffin*, No. 1:03-CV-140, 2004 WL 1854165, at *2 (E.D. Tenn. Jan. 6, 2004) (holding that complete preemption gives rise to "federal question jurisdiction over any claim for reimbursement related to a FEHBA plan and such claims would necessarily arise under federal common law"); *Estate of Williams-Moore v. Alliance One Receivables Mgmt., Inc.*, 335 F. Supp. 2d 636, 652 (M.D.N.C. 2004) ("[M]any courts now hold that the FEHBA completely preempts all state law claims that relate to health insurance or plans, regardless of whether they are inconsistent with the contractual provisions.").

This Court recently examined FEHBA and its federal remedial scheme in *Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677 (2006). In *Empire*, the Court held that FEHBA's exclusive federal remedies did not "extend" to "reimbursement claims between carriers and insured workers." *Id.* at 696. The Court, however, carefully distinguished these claims from benefits disputes, which are covered by the federal enforcement scheme. *Id.* The Court made clear that the FEHBA enforcement

provisions "ensure that suits *brought by the beneficiaries* for denial of benefits will land in federal court." *Id.* (citations omitted) (emphasis added). In contrast, the Court explained that "[h]ad Congress found it necessary or proper to extend federal jurisdiction . . . to encompass contract-derived reimbursement claims between carriers and insured workers" then Congress could have so stated. *Id.* Unlike in *Empire*, where a health insurance carrier brought an action against the estate of a former enrollee, in *Pollitt*, the federal remedial scheme squarely applies to the benefit and enrollment claims brought by a beneficiary. Accordingly, *Empire* supports the application of complete preemption to benefits disputes that are covered by FEHBA remedial scheme.

b. The Breadth of the FEHBP Statutory Preemption Provision Further Supports Complete Preemption of State Law Claims for FEHBP Enrollment and Benefits

In conjunction with the FEHBP's regime for administrative and judicial review of claims denials, the broad express preemption of state law in FEHBP supports complete preemption of the Respondents' claims.

FEHBA's preemption provision provides:

> The terms of any contract under this chapter which relate to the nature,

> provision or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1). Each FEHBP contract, in turn, describes the benefits to be provided, the process for enrollment, and the federally prescribed pathway for resolution of disputes regarding claim denials. *Id.* § 8902(d), (g), (j); 5 C.F.R. §§ 890.105(a)(1), 890.104(a), 890.107(a), (c).

In its original iteration, FEHBA's preemption provision extended only to state and local laws and regulations "inconsistent with [FEHBP] contractual provisions." *Botsford*, 314 F.3d at 393. Several courts used this language to distinguish FEHBA's preemption language from ERISA, and to hold that FEHBA did not provide complete preemption. *See id.* at 393. However, in 1998, Congress amended FEHBA and removed the requirement for preemption that state laws and regulations be "inconsistent." The amended provision provides that the terms of any FEHBP contract "shall supersede and preempt any State of local law, or any regulation issued thereunder, which relates to health insurance plans." 5 U.S.C. § 8902(m)(1).

Removal of the "inconsistent" language illustrated Congress' intent to preempt state law and bring "FEHBA's preemption on par with that of ERISA." *See, e.g., Rievley v. Blue Cross Blue Shield of Tenn.*, 69 F. Supp. 2d 1028, 1034 (E.D. Tenn.

1999). This conclusion is strengthened by the language in the House Report that "confirms the intent of Congress" that FEHBA contract terms "which relate to the nature or extent of coverage or benefits . . . completely displace" local and state laws. H.R. Rep. No. 105-374, at 16 (1997); *see also McCoy v. Unicare Life and Health Ins. Co.*, No. 04 C 1126, 2004 WL 2358277, at *5 (N.D. Ill. Oct. 18, 2004) (emphasizing that "Congress has indicated that the complete preemption doctrine is applicable" to FEHBA benefits claims).

While mere preemption of a state law by express Congressional preemption language does not inherently evidence "complete preemption" permitting removal to federal court, the federally created FEHBP remedial scheme, in conjunction with the broad FEHBA preemption language, as amended, supports complete preemption.

c. In Two Key Respects, The Statutory Basis For FEHBP Complete Preemption Is Even Stronger Than under ERISA

Compared to ERISA, the FEHBP scheme even more plainly favors an exclusively federal forum for claims disputes in two key respects.

The first concerns their respective statutory preemption language. ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ," but excepts from preemption state laws regulating insurance,

banking and securities, through what is commonly referred to as the ERISA preemption "savings clause." *See* 29 U.S.C. § 1144(a), (b)(2)(A). Thus, in mandating preemption in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), of *all* state law claims for benefits under ERISA plans, even if the state law claim purported to be based on insurance law and was against an insurance company, this Court had to put in context the ERISA "savings clause" by focusing on the intended exclusivity of ERISA's Section 502(a)(1)(B) remedial scheme.

In FEHBA, in contrast, Congress has expressly preempted all state law claims for the benefits provided under FEHBP contracts. State law claims are preempted whether they purport to arise under state insurance law or not, and whether or not they are made against the government or against the contracting health benefit plan or carrier. *See* 5 U.S.C. § 8902(m)(1). Here, there is no "saving clause" to be construed. The FEHBA statutory preemption language is on its face stronger than ERISA's in this regard. In conjunction with the remedies afforded through the exclusively federal forums contemplated in the remedial scheme created under the FEHBP, the case for complete preemption is all the stronger.

Second, Congress specifically provided in ERISA that state courts have concurrent jurisdiction over ERISA plan participants' federal claims for benefits. 29 U.S.C. § 1132(e). Despite this provision contemplating a state court forum for pursuit of federal ERISA claims, the Court has nonetheless

found that the federal scheme completely preempts state law claims creating a sufficient basis for removal under ERISA, even with respect to claims that, once understood as properly raising a federal claim, may properly be maintained in state court. *See generally Davila*, 542 U.S. 200. In contrast, the FEHBP scheme for review and adjudication of claim denial disputes is exclusively federal, with no recognition of state courts as an appropriate forum in any respect. *See* 5 U.S.C. § 8912; 5 C.F.R. §§ 890.105(a)(1), 890.107(c). The case for complete preemption and removal to federal court is in that respect even stronger than in ERISA.

d. The Jurisdictional Language of FEHBA Is Consistent With Complete Preemption.

In determining whether complete preemption applies, in *Metropolitan Life*, the Court considered the language in ERISA's jurisdictional subsection, Section 502(f). *Metropolitan Life*, 481 U.S. at 65. With regard to FEHBA, the jurisdictional provision provides: "The district courts of the United States have original jurisdiction, concurrent with the United States Court of Federal Claims, of a civil action or claim against the United States founded on this chapter." 5 U.S.C. § 8912. The jurisdictional provisions of ERISA and LMRA, are phrased more broadly, "creat[ing] federal jurisdiction over various parties, and various defendants, not merely the United States." *Botsford*, 314 F.3d at 397 (discussing 29 U.S.C. § 1132(f); 29 U.S.C. § 185(a)

(LMRA)); 29 U.S.C. § 1132(f) ("The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.").

Comparing ERISA § 502(f) to the FEHBA jurisdiction provision at 5 U.S.C. § 8912, the *Botsford* court concluded that while the jurisdiction statement may seem "narrower," when "considered in the context of the entire statute and its purposes," the language "is as broad as it can be." *Botsford,* 314 F.3d at 397. The differences are readily explained by differences in the scope of the statutes. ERISA covers health plans offered by private parties, and permits lawsuits to be brought against employers or plan administrators. *Id.* at 398. The LMRA, similarly, governs private sector labor-management matters. FEHBA, however, involves only one employer – the United States – and the regulatory scheme contemplates only a single defendant in any resultant coverage or benefits litigation – again the United States. *Id.* Accordingly, as explained in *Botsford*, FEHBA's remedial scheme and jurisdiction provision are intended to ensure that lawsuits are brought only against the United States. *Id.* Because the federal remedies provided in the remedial scheme are the "only intended remedies under FEHBA, . . . the federal remedies displace state remedies." *Id.*

In brief, Congress's language is more than sufficient to support complete preemption where the employee benefits program claims involve the

employees of the United States itself, when complete preemption has already been found with respect to the claims of plan participant employees of private employers. Complete preemption is, therefore, proper.

e. Complete Preemption is Further Supported by FEHBA's Goal of "Uniform Administration"

As explained in *Botsford*, Congress sought to create a "cost-efficient" and "comprehensive" health care coverage program for federal employees. *Botsford*, 314 F.3d at 395. A separate – and for this analysis significant – goal was to "achieve uniform administration of FEHBA plans." *Id.* If cases like the Respondents' proceed in state courts, the "application of different state standards would disrupt the nationally uniform administration" of FEHBA benefits. *Id.* Moreover, the "disruption would increase administrative costs," thereby increasing the overall cost of federal health care benefits. *Id.* Permitting these cases to proceed in state courts under varying state laws would "undermine congressional intent." *Id.*

For the reasons articulated above, and in Petitioner's Brief on the Merits, complete preemption should apply to claims that are, in fact, seeking FEHBP enrollment or benefits, pursuant to the FEHBA, 5 U.S.C. §§ 8901-14. This makes state court claims challenging enrollment and health benefit determinations removable to federal court.

B. The Federal Officer Removal Statute Provides Federal Courts Jurisdiction Over Respondents' Claims

1. The Federal Officer Removal Statute

The federal officer removal statute provides that a civil action may be removed to federal court when

> [t]he United States or any agency thereof or any officer (*or any person acting under that officer*) of the United States or of any agency thereof, sued in an official or individual capacity for any act under color of such office or on account of any right, title or authority claimed under any Act of Congress for the apprehension or punishment of criminals or the collection of the revenue.

28 U.S.C. § 1442(a)(1) (emphasis added). The words "acting under" any officer of an agency "are broad, and . . . must be 'liberally construed.'" *Watson v. Philip Morris Cos.*, 551 U.S. 142, 147 (2007), (quoting *Colorado v. Symes*, 286 U.S. 510, 517 (1932)).

The Court has recognized the availability of § 1442(a)(1) as a basis for removal by government contractors acting at the direction of federal officers. In *Watson*, the Court noted that in contrast to regulated private corporations, "[t]he assistance that private [government] contractors provide federal officers goes beyond simple compliance with the law

and helps officers fulfill other basic governmental tasks." *Watson*, 551 U.S. at 153. Where a government contractor is sued, and "the relationship between the contractor and the Government is an unusually close one involving detailed regulation, monitoring, or supervision" that "helps fulfill basic governmental tasks," removal under § 1442(a)(1) is proper. *Id.* at 153-54; *see also Isaacson v. Dow Chem. Co.*, 517 F.3d 129, 137 (2d Cir. 2008) (upholding removal by government contractor under § 1442(a)(1)).

FEHBP plans are subject to comprehensive and particularly close federal regulation covering virtually every aspect of their operations, including their qualifications for contracting, claims processing, coverage requirements, enrollment eligibility and processing, payments to providers, subscription rates, government review and approval of their member coverage brochures, and the review and appeals process for claim denials, laid out not only in their government contract but also in more than 140 pages of federal regulations, a "carrier handbook," additional reporting requirements, and a series of annual "carrier letters" providing additional instruction. *See* 48 C.F.R. parts 1600 - 1699; 5 C.F.R. part 890; FEHB Carrier Letters and Carrier Handbook, *available at* http://www.opm.gov/carrier/. Furthermore, providing health benefits to its own employees is a basic government task carried out via the Employees Health Benefits Fund established by Congress in the Treasury of the United States for all payments to health benefits plans in the FEHBP. *See* 5 U.S.C. § 8909(a).

Application of the federal officer removal statute in the FEHBA context should parallel its application to contractors under the TRICARE and Medicare programs.

2. TRICARE

While FEHBA provides health care benefits to active and retired civilian employees of the United States government, the TRICARE program provides similar benefits to military personnel and their dependents. In 1967, the United States Department of Defense established the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS"), a civilian health care program for members of the United States armed forces and their dependents. *See* 10 U.S.C. § 1071; *see also* 32 C.F.R. § 199.3 (designating beneficiaries). In 1995 the Defense Department established TRICARE, a managed care program covering the same beneficiaries as CHAMPUS and supplementing CHAMPUS. Like FEHBA, under TRICARE, private regional contractors process health care services claims pursuant to contracts between the contractors and the Department of Defense.

Courts have concluded that claims relating to benefits coverage and payment under CHAMPUS/TRICARE are subject to removal under the federal officer removal statute where the state court claims "stem from the defendants' activities administering claims on behalf of the federal government." *See Lombardi v. Triwest Healthcare Alliance Corp.*, No. CV-08-02381-PHX-FJM, 2009 WL 1212170, at *2 (D. Ariz. May 4, 2009).

For example, in *Lombardi v. Triwest Healthcare Alliance Corp.*, the plaintiff sued the government contractor administrating his TRICARE benefits after his wife's claims were denied or left unpaid. *Id.* at *1. Like Respondents here, the plaintiff asserted state tort claims including emotional distress allegedly suffered as a result of the unpaid claims. *Id.* Also like here, after the lawsuit was filed, the defendant voluntarily paid all outstanding claims, then removed the action to federal court on the basis of federal question jurisdiction or the federal officer removal statute. *Id.*

The district court in *Lombardi* held that removal was proper under § 1442(a)(1) because the TRICARE contractors "derive their authority from a detailed system of federal regulations." *Id.* at *2. The District Court thus concluded that the defendants are "closely aligned with the [federal] government" and were "acting under federal control" pursuant to 28 U.S.C. § 1442(a)(1) when defendants undertook the actions alleged in plaintiff's complaint. *Id.* The court concluded that "even if the plaintiff no longer seeks the payment of TRICARE benefits, his claims stem from the defendants' activities administering claims on behalf of the federal government." *Id.*

Likewise, in *Holton v. Blue Cross and Blue Shield of South Carolina*, 56 F. Supp. 2d 1347 (M.D. Ala. 1999), a medical provider sued a CHAMPUS contractor for failure to pay various claims that the plaintiff had submitted. The district court concluded

that when "carrying out its duty to administer [the] CHAMPUS contract" the contractor was "act[ing] under the direction of the officers and of the United States and agencies thereof, and act[ing] under the color and authority of those officers." *Holton*, 56 F. Supp. 2d at 1351. Thus the federal court had jurisdiction to entertain the claim pursuant to 28 U.S.C. § 1442(a)(1).

3. Medicare

In addition to TRICARE and FEHBA, Medicare is another government health benefits program that relies on private parties as government contractors. Medicare, the social insurance program administered by the United States government, principally provides health coverage to people aged 65 and older, and to disabled persons. Medicare provides health coverage for over 43 million Americans. There are four parts to Medicare: (A) Medicare Part A covers, subject to certain time limits and co-payments, inpatient hospital stays and convalescence in nursing facilities; (B) Medicare Part B helps pay for services and products not included in Part A, including physician and nursing services, tests, vaccinations and durable medical equipment; (C) Medicare Part C, also known as Medicare Advantage (formerly known as Medicare Plus Choice), offers Medicare benefits through coordinated care and other contracted health plan programs; and (D) Medicare Part D, prescription drug coverage that requires participation in either a Prescription Drug Plan or a Medicare Advantage Plan with drug coverage.

Courts have found removal appropriate pursuant to 28 U.S.C. § 1442(a)(1) in suits relating to the administration of Medicare benefits brought against private contractors, including fiscal intermediaries and contractors providing private health benefits.[3] *Manorcare Potomac v. Understein*, No. 8:02-CV-1177-T-23EAJ, 2002 WL 31426705, at *1 n.1 (M.D. Fla. Oct. 16, 2002) (holding that removal by third-party defendant Aetna Health Inc., pursuant to Aetna's obligations as a Medicare + Choice provider, satisfies the requirements of 28 U.S.C. 1442(a)(1)); *Lifecare Hosps., Inc. v. Ochsner Health Plan, Inc.*, 139 F. Supp. 2d 768, 770 (W.D. La. 2001) (noting that case brought by hospital against Medicare + Choice plan was removed pursuant to several statutes, including 28 U.S.C. § 1442(a)(1)); *see also Peterson v. Blue Cross/Blue Shield of Tex.*, 508 F.2d 55, 58 (5th Cir. 1975), *cert. denied*, 422 U.S. 1043 (1975); *Reg'l Med. Transp., Inc. v. Highmark, Inc.*, 541 F. Supp. 2d 718, 724-25 (E.D. Pa. 2008);

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[3] The Eleventh Circuit recently held in *Dial v. Healthspring of Alabama, Inc.*, 541 F.3d 1044 (11th Cir. 2008) that federal courts lack subject matter jurisdiction over claims arising under the Medicare Act that are not brought against the Secretary for judicial review in federal court. *Id.* at 1048. Instead of dismissing the improper claims so that the claims could be brought under the federal remedial scheme, the Eleventh Circuit determined it lacked subject matter jurisdiction and ordered that the case be remanded to state court. *Id.* at 1047-48. Respectfully, ACHP believes this aspect of *Dial* was wrongly decided.

Neurological Assoc. v. Blue Cross/Blue Shield of Fla., Inc., 632 F. Supp. 1078 (S.D. Fla. 1986).

A case often cited for this proposition is *Peterson v. Blue Cross/Blue Shield of Texas*, 508 F.2d 55 (5th Cir. 1975). In *Peterson*, a physician brought an action against Blue Cross/Blue Shield of Texas for repayment and in connection with his suspension from practicing within the Medicare program. *Id.* at 56. His claims related to both Medicare Part A and Part B. *See Peterson v. Weinberger*, 508 F.2d 45, 48 (5th Cir. 1975), *cert. denied*, 423 U.S. 830 (1975). The Fifth Circuit concluded that the defendants, as fiscal intermediaries, were "acting pursuant to a contract with the government. . . under the sovereign immunity umbrella." *Peterson*, 508 F.2d at 57-58. The Fifth Circuit explained that the "purpose" of the federal officer removal statute is to "prevent federal officers or persons acting under their direction from being tried in state courts for acts done within the scope of their federal employment." *Id.* at 58. Relying on this Court's mandate that the "federal officer removal statute is not 'narrow' or 'limited'" and that "'the test for removal should be broader, not narrower, than the test for official immunity,'" the Fifth Circuit held that defendants were "persons acting within the purview of § 1442(a)(1) and that the suits were properly removed." *Id.* (citing *Willingham v. Morgan*, 395 U.S. 402, 405 (1969) & *Colorado v. Symes*, 286 U.S. 510, 517 (1932)).

Similarly, courts have concluded that the federal officer removal statute applies to those

contracting to provide Medicare health benefit plans. For example, in *Manorcare Potomac v. Understein*, Aetna Health, Inc., a provider of "Medicare + Choice" benefits (predecessor to the current Medicare Advantage program) pursuant to a contract with the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) of the U.S. Department of Health and Human Services, successfully removed the case to federal court. *Understein*, No. 8:02-CV-1177-T-23EAJ, 2002 WL 31426705, at *1 n.1 (M.D. Fla. Oct. 16, 2002). The Middle District of Florida held that Aetna had "sufficiently allege[d]" that its role as a provider of Medicare benefits "qualifie[d] Aetna as a 'person acting under' an agency or officer of the United States for the purpose of the Federal Officer Removal Statute." *Id.*; *see also Lifecare Hosps.*, 139 F. Supp. 2d at 770 (noting that case brought by hospital against Medicare + Choice plan was removed pursuant to several statutes, including 28 U.S.C. § 1442(a)(1)).

4. FEHBA

The Seventh Circuit applied an incorrect standard for federal officer removal when it focused on whether a government agency specifically directed the action, instead of whether Petitioner's conduct stems from its obligations as a government contractor. *Pollitt*, 558 F.3d at 616-17. The determinative factor for federal officer removal is whether "the acts complained of . . . were taken 'under color of federal office,'" not whether they were specifically directed by the government. *Isaacson*,

517 F.3d at 137 (quoting 28 U.S.C. § 1442(a)(1)). "The hurdle erected by this requirement is quite low" and the contractor "must only establish that the act that is the subject of Plaintiffs' attack . . . occurred *while* Defendants were performing their official duties." *Id.* at 137-38 (emphasis in original). The defendant need not show that the activities underlying the complaint were "specifically contemplated by the government contract." *Id.* at 138. Rather, "it is enough that the contracts gave rise to" those activities. *Id.*

The FEHBA regulations make clear that the federal government is responsible for directing the enrollment and benefits-payment activities of an FEHBP plan. *See* 5 C.F.R. §§ 890.102(a)-(f), 890.103, 890.104. Moreover, while it is the contractor who makes the initial benefits determination, that determination is appealable through the federal administrative agency, and FEHBA regulations require that a "legal action to review final action by OPM involving such denial of health benefits must be brought against OPM *and not against the carrier or carrier's subcontractors.*" 5 C.F.R. § 890.107(c) (emphasis added). It is the government, and not the carrier, who is ultimately responsible for defending the benefit decision. Where the government itself has mandated that claims related to the actions of a government contractor are to be made against the government, and only against the government, it is particularly evident that a suit against the contractor may be removed under the federal officer removal principles. For these reasons and those further articulated in Petitioner's Brief on

the Merits, the Court should find that a suit against a government contractor offering a FEHBA plan for actions taken pursuant to the government contract meets the requirements of 28 U.S.C. § 1442(a)(1) and that such a case can be removed to federal court.

CONCLUSION

For the foregoing reasons, the Court should hold that FEHBA completely preempts - and therefore makes removable to federal court - a state court suit challenging enrollment and health benefit determinations that are subject to the exclusive federal remedial scheme established by FEHBA. Moreover, the Court should find that the federal officer removal statute, 28 U.S.C. § 1442(a)(1) encompasses a suit against a government contractor administering a FEHBA plan, for actions taken pursuant to the government contract.

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December 18, 2009

APPENDIX

APPENDIX

I. STATUTES

FEDERAL EMPLOYEE HEALTH BENEFITS ACT PROVISIONS

5 U.S.C. § 8902. Contracting authority

(a) The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 or 8903a of this title, without regard to section 5 of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(b) To be eligible as a carrier for the plan described by section 8903(2) of this title, a company must be licensed to issue group health insurance in all the States and the District of Columbia.

(c) A contract for a plan described by section 8903(1) or (2) this title shall require the carrier--

(1) to reinsure with other companies which elect to participate, under an equitable formula based on the total amount of their group health insurance benefit payments in the United States during the latest year for which the information is available, to be determined by the carrier and approved by the Office; or

(2) to allocate its rights and obligations under the contract among its affiliates which elect to participate, under an equitable formula to be determined by the carrier and the affiliates and approved by the Office.

(d) Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

(e) The Office may prescribe reasonable minimum standards for health benefits plans described by section 8903 or 8903a of this title and for carriers offering the plans. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of this title. The Office may terminate the contract of a carrier effective at the end of the contract term, if the Office finds that at no time during the preceding two contract terms did the carrier have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan.

(f) A contract may not be made or a plan approved which excludes an individual because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

(g) A contract may not be made or a plan approved which does not offer to each employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title

whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which he may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title who exercises this option shall pay the full periodic charges of the nongroup contract.

(h) The benefits and coverage made available under subsection (g) of this section are noncancelable by the carrier except for fraud, over-insurance, or nonpayment of periodic charges.

(i) Rates charged under health benefits plans described by section 8903 or 8903a of this title shall reasonably and equitably reflect the cost of the benefits provided. Rates under health benefits plans described by section 8903(1) and (2) of this title shall be determined on a basis which, in the judgment of the Office, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers. The rates determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term, based on past experience and benefit adjustments under the later contract. Any readjustment in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Office, is consistent with the general practice of carriers which issue group health benefit plans to large employers.

(j) Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title is entitled thereto under the terms of the contract.

(k)(1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11), an employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in

paragraph (1), if such provider is licensed or certified as such under Federal or State law.

(3) The provisions of this subsection shall not apply to comprehensive medical plans as described in section 8903(4) of this title.

(*l*) The Office shall contract under this chapter for a plan described in section 8903(4) of this title with any qualified health maintenance carrier which offers such a plan. For the purpose of this subsection, "qualified health maintenance carrier" means any qualified carrier which is a qualified health maintenance organization within the meaning of section 1310(d)(1) of title XIII of the Public Health Service Act (42 U.S.C. 300c-9(d)).
(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

(2)(A) Notwithstanding the provisions of paragraph (1) of this subsection, if a contract under this chapter provides for the provision of, the payment for, or the reimbursement of the cost of health services for the care and treatment of any particular health condition, the carrier shall provide, pay, or reimburse up to the limits of its contract for any such health service properly provided by any person licensed under State law to provide such service if such service is provided to an individual covered by such contract in a

State where 25 percent or more of the population is located in primary medical care manpower shortage areas designated pursuant to section 332 of the Public Health Service Act (42 U.S.C. 2543).

(B) The provisions of subparagraph (A) shall not apply to contracts entered into providing prepayment plans described in section 8903(4) of this title.

(n) A contract for a plan described by section 8903(1), (2), or (3), or section 8903a, shall require the carrier –

(1) to implement hospitalization-cost-containment measures, such as measures –

(A) for verifying the medical necessity of any proposed treatment or surgery;

(B) for determining the feasibility or appropriateness of providing services on an outpatient rather than on an inpatient basis;

(C) for determining the appropriate length of stay (through concurrent review or otherwise) in cases involving inpatient care; and

(D) involving case management, if the circumstances so warrant; and

(2) to establish incentives to encourage compliance with measures under paragraph (1).

(o) A contract may not be made or a plan approved which includes coverage for any benefit, item, or service for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

5 U.S.C. § 8903. Health benefit plans

The Office of Personnel Management may contract for or approve the following health benefits plans:

(1) Service Benefit Plan. – One Government-wide plan, which may be underwritten by participating affiliates licensed in any number of States, offering two levels of benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described by section 8904(1) of this title given to employees, annuitants, members of their families, former spouses, or persons having continued coverage under section 8905a of this title, or, under certain conditions, payment is made by a carrier to the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title.

(2) Indemnity Benefit Plan. – One Government-wide plan, offering two levels of benefits, under which a carrier agrees to pay certain sums of money, not in excess of the actual expenses incurred, for benefits of the types described by section 8904(2) of this title.

(3) Employee Organization Plans. – Employee organization plans which offer benefits of the types

referred to by section 8904(3) of this title, which are sponsored or underwritten, and are administered, in whole or substantial part, by employee organizations described in section 8901(8)(A) of this title, which are available only to individuals, and members of their families, who at the time of enrollment are members of the organization.

(4) Comprehensive Medical Plans. –

(A) Group-practice prepayment plans. – Group-practice prepayment plans which offer health benefits of the types referred to by section 8904(4) of this title, in whole or in substantial part on a prepaid basis, with professional services thereunder provided by physicians practicing as a group in a common center or centers. The group shall include at least 3 physicians who receive all or a substantial part of their professional income from the prepaid funds and who represent 1 or more medical specialties appropriate and necessary for the population proposed to be served by the plan.

(B) Individual-practice prepayment plans. – Individual-practice prepayment plans which offer health services in whole or substantial part on a prepaid basis, with professional services thereunder provided by individual physicians who agree, under certain conditions approved by the Office, to accept the payments provided by the plans as full payment for covered services given by them including, in addition to in-hospital services, general care given in their

offices and the patients' homes, out-of-hospital diagnostic procedures, and preventive care, and which plans are offered by organizations which have successfully operated similar plans before approval by the Office of the plan in which employees may enroll.

(C) Mixed model prepayment plans. – Mixed model prepayment plans which are a combination of the type of plans described in subparagraph (A) and the type of plans described in subparagraph (B).

5 U.S.C. § 8909. Employee Health Benefits Fund

(a) There is in the Treasury of the United States an Employees Health Benefits Fund which is administered by the Office of Personnel Management. The contributions of enrollees and the Government described by section 8906 of this title shall be paid into the Fund. The Fund is available--

(1) without fiscal year limitation for all payments to approved health benefits plans; and

(2) to pay expenses for administering this chapter within the limitations that may be specified annually by Congress.

Payments from the Fund to a plan participating in a letter-of-credit arrangement under this chapter shall, in connection with any payment or reimbursement to be made by such plan for a health service or supply, be made, to the maximum extent

practicable, on a checks-presented basis (as defined under regulations of the Department of the Treasury).

(b) Portions of the contributions made by enrollees and the Government shall be regularly set aside in the Fund as follows:

(1) A percentage, not to exceed 1 percent of all contributions, determined by the Office to be reasonably adequate to pay the administrative expenses made available by subsection (a) of this section.

(2) For each health benefits plan, a percentage, not to exceed 3 percent of the contributions toward the plan, determined by the Office to be reasonably adequate to provide a contingency reserve.

The Office, from time to time and in amounts it considers appropriate, may transfer unused funds for administrative expenses to the contingency reserves of the plans then under contract with the Office. When funds are so transferred, each contingency reserve shall be credited in proportion to the total amount of the subscription charges paid and accrued to the plan for the contract term immediately before the contract term in which the transfer is made. The income derived from dividends, rate adjustments, or other refunds made by a plan shall be credited to its contingency reserve. The contingency reserves may be used to defray increases in future rates, or may be applied to reduce the contributions of enrollees and the Government to, or to increase the benefits provided by, the plan

from which the reserves are derived, as the Office from time to time shall determine.

(c) The Secretary of the Treasury may invest and reinvest any of the money in the Fund in interest-bearing obligations of the United States, and may sell these obligations for the purposes of the Fund. The interest on and the proceeds from the sale of these obligations become a part of the Fund.

(d) When the assets, liabilities, and membership of employee organizations sponsoring or underwriting plans approved under section 8903(3) or 8903a of this title are merged, the assets (including contingency reserves) and liabilities of the plans sponsored or underwritten by the merged organizations shall be transferred at the beginning of the contract term next following the date of the merger to the plan sponsored or underwritten by the successor organization. Each employee, annuitant, former spouse, or person having continued coverage under section 8905a of this title affected by a merger shall be transferred to the plan sponsored or underwritten by the successor organization unless he enrolls in another plan under this chapter. If the successor organization is an organization described in section 8901(8)(B) of this title, any employee, annuitant, former spouse, or person having continued coverage under section 8905a of this title so transferred may not remain enrolled in the plan after the end of the contract term in which the merger occurs unless that individual is a full member of such organization (as determined under section 8903a(d) of this title).

(e)(1) Except as provided by subsection (d) of this section, when a plan described by section 8903(3) or (4) or 8903a of this title is discontinued under this chapter, the contingency reserve of that plan shall be credited to the contingency reserves of the plans continuing under this chapter for the contract term following that in which termination occurs, each reserve to be credited in proportion to the amount of the subscription charges paid and accrued to the plan for the year of termination.

(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.

(f)(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any carrier or underwriting or plan administration

subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such carrier or underwriting or plan administration subcontractor from business conducted under this chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(g) The fund described in subsection (a) is available to pay costs that the Office incurs for activities associated with implementation of the demonstration project under section 1108 of title 10.

5 U.S.C. § 8912. Jurisdiction of courts

The district courts of the United States have original jurisdiction, concurrent with the United States Court of Federal Claims, of a civil action or claim against the United States founded on this chapter.

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES PROVISION

10 U.S.C. § 1071. Purpose of this chapter

The purpose of this chapter is to create and maintain high morale in the uniformed services by providing an improved and uniform program of medical and dental care for members and certain former members of those services, and for their dependents.

NATIONAL BANK ACT PROVISIONS

12 U.S.C. § 85. Rate of interest on loans, discounts and purchases

Any association may take, receive, reserve, and charge on any loan or discount made, or upon any notes, bills of exchange, or other evidences of debt, interest at the rate allowed by the laws of the State, Territory, or District where the bank is located, or at a rate of 1 per centum in excess of the discount rate on ninety-day commercial paper in effect at the Federal reserve bank in the Federal reserve district where the bank is located, whichever may be the greater, and no more, except that where by the laws of any State a different rate is limited for banks organized under state laws, the rate so limited shall be allowed for associations organized or existing in any such State under title 62 of the Revised Statutes. When no rate is fixed by the laws of the State, or Territory, or District, the bank may take, receive, reserve, or charge a rate not exceeding 7 per centum, or 1 per centum in excess of the discount rate on ninety-day commercial paper in effect at the Federal reserve bank in the Federal reserve district where the bank is located, whichever may be the greater, and such interest may be taken in advance, reckoning the days for which the note, bill, or other evidence of debt has to run. The maximum amount of interest or discount to be charged at a branch of an association located outside of the States of the United States and the District of Columbia shall be at the rate allowed by the laws of the country, territory, dependency, province, dominion, insular

possession, or other political subdivision where the branch is located. And the purchase, discount, or sale of a bona fide bill of exchange, payable at another place than the place of such purchase, discount, or sale, at not more than the current rate of exchange for sight drafts in addition to the interest, shall not be considered as taking or receiving a greater rate of interest.

12 U.S.C. § 86. Usurious interest; penalty for taking; limitations

The taking, receiving, reserving, or charging a rate of interest greater than is allowed by section 85 of this title, when knowingly done, shall be deemed a forfeiture of the entire interest which the note, bill, or other evidence of debt carries with it, or which has been agreed to be paid thereon. In case the greater rate of interest has been paid, the person by whom it has been paid, or his legal representatives, may recover back, in an action in the nature of an action of debt, twice the amount of the interest thus paid from the association taking or receiving the same: *Provided,* That such action is commenced within two years from the time the usurious transaction occurred

JUDICIARY AND JUDICIAL PROCEDURE PROVISIONS

28 U.S.C. § 1441. Actions removable generally

(a) Except as otherwise expressly provided by Act of Congress, any civil action brought in a State court of

which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending. For purposes of removal under this chapter, the citizenship of defendants sued under fictitious names shall be disregarded.

(b) Any civil action of which the district courts have original jurisdiction founded on a claim or right arising under the Constitution, treaties or laws of the United States shall be removable without regard to the citizenship or residence of the parties. Any other such action shall be removable only if none of the parties in interest properly joined and served as defendants is a citizen of the State in which such action is brought.

(c) Whenever a separate and independent claim or cause of action within the jurisdiction conferred by section 1331 of this title is joined with one or more otherwise non-removable claims or causes of action, the entire case may be removed and the district court may determine all issues therein, or, in its discretion, may remand all matters in which State law predominates.

(d) Any civil action brought in a State court against a foreign state as defined in section 1603(a) of this title may be removed by the foreign state to the district court of the United States for the district and division embracing the place where such action is pending. Upon removal the action shall be tried by the court without jury. Where removal is based upon

this subsection, the time limitations of section 1446(b) of this chapter may be enlarged at any time for cause shown.

(e)(1) Notwithstanding the provisions of subsection (b) of this section, a defendant in a civil action in a State court may remove the action to the district court of the United States for the district and division embracing the place where the action is pending if—

> (A) the action could have been brought in a United States district court under section 1369 of this title; or
>
> (B) the defendant is a party to an action which is or could have been brought, in whole or in part, under section 1369 in a United States district court and arises from the same accident as the action in State court, even if the action to be removed could not have been brought in a district court as an original matter.

The removal of an action under this subsection shall be made in accordance with section 1446 of this title, except that a notice of removal may also be filed before trial of the action in State court within 30 days after the date on which the defendant first becomes a party to an action under section 1369 in a United States district court that arises from the same accident as the action in State court, or at a later time with leave of the district court.

(2) Whenever an action is removed under this subsection and the district court to which it is removed or transferred under section 1407(j) has made a liability determination requiring further proceedings as to damages, the district court shall remand the action to the State court from which it had been removed for the determination of damages, unless the court finds that, for the convenience of parties and witnesses and in the interest of justice, the action should be retained for the determination of damages.

(3) Any remand under paragraph (2) shall not be effective until 60 days after the district court has issued an order determining liability and has certified its intention to remand the removed action for the determination of damages. An appeal with respect to the liability determination of the district court may be taken during that 60-day period to the court of appeals with appellate jurisdiction over the district court. In the event a party files such an appeal, the remand shall not be effective until the appeal has been finally disposed of. Once the remand has become effective, the liability determination shall not be subject to further review by appeal or otherwise.

(4) Any decision under this subsection concerning remand for the determination of damages shall not be reviewable by appeal or otherwise.

(5) An action removed under this subsection shall be deemed to be an action under section 1369 and an action in which jurisdiction is based on section

1369 of this title for purposes of this section and sections 1407, 1697, and 1785 of this title.

(6) Nothing in this subsection shall restrict the authority of the district court to transfer or dismiss an action on the ground of inconvenient forum.

(f) The court to which a civil action is removed under this section is not precluded from hearing and determining any claim in such civil action because the State court from which such civil action is removed did not have jurisdiction over that claim.

28 U.S.C. § 1442. Federal officers or agencies sued or prosecuted

(a) A civil action or criminal prosecution commenced in a State court against any of the following may be removed by them to the district court of the United States for the district and division embracing the place wherein it is pending:

(1) The United States or any agency thereof or any officer (or any person acting under that officer) of the United States or of any agency thereof, sued in an official or individual capacity for any act under color of such office or on account of any right, title or authority claimed under any Act of Congress for the apprehension or punishment of criminals or the collection of the revenue.

(2) A property holder whose title is derived from any such officer, where such action or prosecution

affects the validity of any law of the United States.

(3) Any officer of the courts of the United States, for any act under color of office or in the performance of his duties;

(4) Any officer of either House of Congress, for any act in the discharge of his official duty under an order of such House.

(b) A personal action commenced in any State court by an alien against any citizen of a State who is, or at the time the alleged action accrued was, a civil officer of the United States and is a nonresident of such State, wherein jurisdiction is obtained by the State court by personal service of process, may be removed by the defendant to the district court of the United States for the district and division in which the defendant was served with process.

LABOR MANAGEMENT RELATIONS ACT PROVISION

29 U.S.C. § 185. Suits by and against labor organizations

(a) Venue, amount, and citizenship

Suits for violation of contracts between an employer and a labor organization representing employees in an industry affecting commerce as defined in this chapter, or between any such labor organizations, may be brought in any district court of the United States having jurisdiction of the parties, without

respect to the amount in controversy or without regard to the citizenship of the parties.

(b) Responsibility for acts of agent; entity for purposes of suit; enforcement of money judgments

Any labor organization which represents employees in an industry affecting commerce as defined in this chapter and any employer whose activities affect commerce as defined in this chapter shall be bound by the acts of its agents. Any such labor organization may sue or be sued as an entity and in behalf of the employees whom it represents in the courts of the United States. Any money judgment against a labor organization in a district court of the United States shall be enforceable only against the organization as an entity and against its assets, and shall not be enforceable against any individual member or his assets.

(c) Jurisdiction

For the purposes of actions and proceedings by or against labor organizations in the district courts of the United States, district courts shall be deemed to have jurisdiction of a labor organization (1) in the district in which such organization maintains its principal office, or (2) in any district in which its duly authorized officers or agents are engaged in representing or acting for employee members.

(d) Service of process

The service of summons, subpena, or other legal process of any court of the United States upon an

officer or agent of a labor organization, in his capacity as such, shall constitute service upon the labor organization.

(e) Determination of question of agency

For the purposes of this section, in determining whether any person is acting as an "agent" of another person so as to make such other person responsible for his acts, the question of whether the specific acts performed were actually authorized or subsequently ratified shall not be controlling.

EMPLOYEE RETIREMENT INCOME SECURITY ACT PROVISIONS

29 U.S.C. § 1132(a), (e), (f). Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought--

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6), (7), (8), or (9) of subsection (c) of this section or under subsection (i) or (l) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection;

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts; or

(10) in the case of a multiemployer plan that has been certified by the actuary to be in endangered or critical status under section 1085 of this title, if the plan sponsor –

(A) has not adopted a funding improvement or rehabilitation plan under that section by the deadline established in such section, or

(B) fails to update or comply with the terms of the funding improvement or rehabilitation plan in accordance with the requirements of such section,

by an employer that has an obligation to contribute with respect to the multiemployer plan or an employee organization that represents active participants in the multiemployer plan, for an order compelling the plan sponsor to adopt a

funding improvement or rehabilitation plan or to update or comply with the terms of the funding improvement or rehabilitation plan in accordance with the requirements of such section and the funding improvement or rehabilitation plan.

* * *

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1201(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant

the relief provided for in subsection (a) of this section in any action.

* * *

29 U.S.C. § 1144(a), b(1), b(2). Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust

established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * *

II. REGULATIONS

FEDERAL EMPLOYEE HEALTH BENEFITS ACT REGULATIONS

5 C.F.R. § 890.102. Coverage

(a) Each employee, other than those excluded by paragraph (c) of this section, is eligible to be enrolled in a health benefits plan at the time and under the conditions prescribed in this part.

(b) An employee who serves in cooperation with non-Federal agencies and is paid in whole or in part from non-Federal funds may register to be enrolled within the period prescribed by OPM for the group of which the employee is a member following approval by OPM of arrangements providing that (1) the required withholdings and contributions will be made from Federally-controlled funds and timely deposited into the Employees Health Benefits Fund, or (2) the cooperating non-Federal agency will, by written agreement with the Federal agency, make the required withholdings and contributions from

non-Federal funds and transmit them for timely deposit into the Employees Health Benefits Fund.

(c) The following employees are not eligible:

(1) An employee (other than an acting postmaster, a Presidential appointee appointed to fill an unexpired term, and an appointee whose appointment meets the definition of provisional appointment set out in §§ 316.401 and 316.403 of this chapter) who is serving under an appointment limited to 1 year or less and who has not completed 1 year of current continuous employment, excluding any break in service of 5 days or less.

(2) An employee who is expected to work less than 6 months in each year, except for an employee who is employed under an OPM approved career-related work-study program under Schedule B of at least 1 year's duration and who is expected to be in a pay status for at least one-third of the total period of time from the date of the first appointment to the completion of the work-study program.

(3) An intermittent employee – a non-full-time employee without a prearranged regular tour of duty.

(4) A beneficiary or patient employee in a Government hospital or home.

(5) An employee paid on a contract or fee basis, except an employee who is a citizen of the United

States who is appointed by a contract between the employee and the Federal employing authority which requires his personal service and is paid on the basis of units of time.

(6) An employee paid on a piecework basis, except one whose work schedule provides for full-time service or part-time service with a regular tour of duty.

(7) An individual first employed by the government of the District of Columbia on or after October 1, 1987. However, this exclusion does not apply to:

(i) Employees of St. Elizabeth's Hospital who accept offers of employment with the District of Columbia government without a break in service, as provided in section 6 of Pub.L. 98-621 (98 Stat. 3379);

(ii) The Corrections Trustee and the Pretrial Services, Defense Services Parole, Adult Probation and Offender Supervision Trustee and employees of these Trustees who accept employment with the District of Columbia government within 3 days after separating from the Federal Government; and

(iii) Effective October 1, 1997, judges and nonjudicial employees of the District of Columbia Courts, as provided by Pub.L. 105-33 (111 Stat. 251).

(8) An individual first employed by the

government of the District of Columbia on or after October 1, 1987. However, this exclusion does not apply to:

(i) Employees of St. Elizabeth's Hospital who accept offers of employment with the District of Columbia government without a break in service, as provided in section 6 of Pub.L. 98-621 (98 Stat. 3379);

(ii) The Corrections Trustee and the Pretrial Services, Parole, Audit Probation and Offender Supervision Trustee and employees of these Trustees who accept employment with the District of Columbia government within 3 days after separating from the Federal Government;

(iii) Effective October 1, 1997, judges and nonjudicial employees of the District of Columbia Courts, as provided by Pub.L. 105-33 (111 Stat. 251); and

(iv) Effective April 1, 1999, employees of the Public Defender Service of the District of Columbia, as provided by Pub.L. 105-274 (112 Stat. 2419).

(d) Paragraph (c) of this section does not deny coverage to:

(1) An employee appointed to perform "part-time career employment," as defined in section 3401(2) of title 5, United States Code, and 5 CFR part 340, subpart B; or

(2) An employee serving under an interim appointment established under § 772.102 of this chapter.

(e) The Office of Personnel Management makes the final determination of the applicability of this section to specific employees or groups of employees.

(f) An employee of the District of Columbia Financial Responsibility and Management Assistance Authority (the Authority) who makes an election under the Technical Corrections to Financial Responsibility and Management Assistance Act (section 153 of Pub.L. 104-134, 110 Stat. 1321) to be considered a Federal employee for health benefits and other benefit purposes is subject to this part. If the employee is eligible to make an election to enroll under § 890.301, such election must be made within 60 days after the later of either the date the employment with the Authority begins or the date the Authority receives his or her election to be considered a Federal employee. Employees of the Authority who are former Federal employees are subject to the provisions of § 890.303(a), except that a former Federal employee employed by the Authority before October 26, 1996, and within 3 days following the termination of the Federal employment may make an election to enroll under § 890.301(c). Annuitants who have continued their coverage under this part as annuitants are not eligible to enroll under this paragraph. An election to enroll under this part is effective under the provisions of § 890.306(a) unless the employee requests the Authority to make the enrollment effective on the

first day of the first pay period following the date the employee entered on duty in a pay status with the Authority.

(g) Notwithstanding any other provision in this part, the hiring of a Federal employee, whether in pay status or nonpay status, for a temporary, intermittent position with the decennial census has no effect on the withholding or Government contribution for his/her coverage or the determination of when 365 days in nonpay status ends.

5 C.F.R. § 890.103. Correction of errors

(a) The employing office may make prospective corrections of administrative errors as to enrollment at any time. The employing office may make retroactive corrections of administrative errors that occur after December 31, 1994.

(b) OPM may order correction of an administrative error upon a showing satisfactory to OPM that it would be against equity and good conscience not to do so.

(c) The employing office may make retroactive correction of enrollee enrollment code errors if the enrollee reports the error by the end of the pay period following the one in which he or she received the first written documentation (i.e. pay statement or enrollment change confirmation) indicating the error.

(d) OPM may order the termination of an enrollment in any comprehensive medical plan described in section 8903(4) of title 5, United States Code, and permit the individual to enroll in another health benefits plan for purposes of this part, upon a showing satisfactory to OPM that the furnishing of adequate medical care is jeopardized by a seriously impaired relationship between a patient and the comprehensive medical plan's affiliated health care providers.

(e) Retroactive corrections are subject to withholdings and contributions under the provisions of § 890.502.

5 C.F.R. § 890.104. Initial decision and reconsideration enrollment

(a) Who may file. Except as provided under § 890.1112, an individual may request an agency or retirement system to reconsider an initial decision of its employing office denying coverage or change of enrollment.

(b) Initial employing office decision. An employing office's decision is considered an initial decision as used in paragraph (a) of this section when rendered by the employing office in writing and stating the right to an independent level of review (reconsideration) by the agency or retirement system. However, an initial decision rendered at the highest level of review available within OPM is not subject to reconsideration.

(c) Reconsideration.

(1) A request for reconsideration must be made in writing, must include the claimant's name, address, date of birth, Social Security number, name of carrier, reason(s) for the request, and, if applicable, retirement claim number.

(2) The reconsideration review must be an independent review designated at or above the level at which the initial decision was rendered.

(d) Time limit. A request for reconsideration of an initial decision must be filed within 30 calendar days from the date of the written decision stating the right to a reconsideration. The time limit on filing may be extended when the individual shows that he or she was not notified of the time limit and was not otherwise aware of it, or that he or she was prevented by circumstances beyond his or her control from making the request within the time limit. An agency or retirement system decision in response to a request for reconsideration of an employing office's decision is a final decision as described in paragraph (e) of this section.

(e) Final decision. After reconsideration, the agency or retirement system must issue a final decision, which must be in writing and must fully set forth the findings and conclusions.

5 C.F.R. § 890.105. Filing claims for payment or service

(a) General.

(1) Each health benefits carrier resolves claims filed under the plan. All health benefits claims must be submitted initially to the carrier of the covered individual's health benefits plan. If the carrier denies a claim (or a portion of a claim), the covered individual may ask the carrier to reconsider its denial. If the carrier affirms its denial or fails to respond as required by paragraph (c) of this section, the covered individual may ask OPM to review the claim. A covered individual must exhaust both the carrier and OPM review processes specified in this section before seeking judicial review of the denied claim.

(2) This section applies to covered individuals and to other individuals or entities who are acting on the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) Time limits for reconsidering a claim.

(1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the carrier in which to submit a written request for reconsideration to the carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the carrier's notice requesting additional information. The carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this section if the carrier fails to act within the time limit set forth in this paragraph (b)(2)(iii).

(3) The covered individual may write to OPM and request that OPM review the carrier's decision if the carrier either affirms its denial of a claim or fails to respond to a covered individual's written

request for reconsideration within the time limit set forth in paragraph (b)(2) of this section. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this section.

(4) The carrier may extend the time limit for a covered individual's submission of additional information to the carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) Information required to process requests for reconsideration.

(1) The covered individual must put the request to the carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the carrier needs additional information from the covered individual to make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) Carrier determinations. The carrier must provide written notice to the covered individual of its determination. If the carrier affirms the initial denial, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the carrier's denial notice and include a copy of the denial notice as well as documents to support the covered individual's position.

(e) OPM review.

(1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the carrier's notice to the covered individual that the denial was affirmed;

(ii) If the carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this section, within 120 days after the date of the covered individual's timely request for reconsideration by the carrier; or

(iii) Within 120 days after the date the carrier requests additional information from the covered individual, or the date the covered individual is notified that the carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the carrier, OPM may:

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the carrier, the carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this section, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the carrier.

(5) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

5 C.F.R. § 890.107. Court review

(a) A suit to compel enrollment under § 890.102 must be brought against the employing office that made the enrollment decision.

(b) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(c) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (5 U.S.C. chapter 89). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the carrier or carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the carrier to pay the amount of benefits in dispute.

(d) An action under paragraph (c) of this section to recover on a claim for health benefits:

(1) May not be brought prior to exhaustion of the administrative remedies provided in § 890.105;

(2) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(3) Will be limited to the record that was before OPM when it rendered its decision affirming the carrier's denial of benefits.

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES REGULATIONS

32 C.F.R. § 199.3. Eligibility

(a) General. – This section sets forth those persons who, by the provisions of 10 U.S.C. chapter 55, and the NATO Status of Forces Agreement, are eligible for CHAMPUS benefits. A determination that a person is eligible does not automatically entitle such a person to CHAMPUS payments. Before any CHAMPUS benefits may be extended, additional requirements, as set forth in other sections of this part, must be met. Additionally, the use of CHAMPUS may be denied if a Uniformed Service medical treatment facility capable of providing the needed care is available. CHAMPUS relies primarily on the Defense Enrollment Eligibility Reporting System (DEERS) for eligibility verification.

(b) CHAMPUS eligibles –

(1) Retiree. A member or former member of a Uniformed Service who is entitled to retired, retainer, or equivalent pay based on duty in a Uniformed Service.

(2) Dependent. Individuals whose relationship to the sponsor leads to entitlement to benefits. CHAMPUS eligible dependents include the following:

(i) Spouse. A lawful husband or wife of a member or former member. The spouse of a deceased

member or retiree must not be remarried. A former spouse also may qualify for benefits as a dependent spouse. A former spouse is a spouse who was married to a military member, or former member, but whose marriage has been terminated by a final decree of divorce, dissolution or annulment. To be eligible for CHAMPUS benefits, a former spouse must meet the criteria described in paragraphs (b)(2)(i)(A) through (b)(2)(i)(E) of this section and must qualify under the group defined in paragraph (b)(2)(i)(F)(1) or (b)(2)(i)(F)(2) of this section.

(A) Must be unremarried; and

(B) Must not be covered by an employer-sponsored health plan; and

(C) Must have been married to a member or former member who performed at least 20 years of service which can be credited in determining the member's or former member's eligibility for retired or retainer pay; and

(D) Must not be eligible for Part A of Title XVIII of the Social Security Act (Medicare) except as provided in paragraphs (b)(3), (f)(3)(vii), (f)(3)(viii), and (f)(3)(ix) of this section; and

(E) Must not be the dependent of a NATO member; and

(F) Must meet the requirements of paragraph (b)(2)(i)(F)(1) or (b)(2)(i)(F)(2) of this section:

(1) The former spouse must have been married to the same member or former member for at least 20 years, at least 20 of which were creditable in determining the member's or former member's eligibility for retired or retainer pay. Eligibility continues indefinitely unless affected by any of the conditions of paragraphs (b)(2)(i)(A) through (b)(2)(i)(E) of this section.

(i) If the date of the final decree of divorce, dissolution, or annulment was before February 1, 1983, the former spouse is eligible for CHAMPUS coverage of health care received on or after January 1, 1985.

(ii) If the date of the final decree of the divorce, dissolution, or annulment was on or after February 1, 1983, the former spouse is eligible for CHAMPUS coverage of health care which is received on or after the date of the divorce, dissolution, or annulment.

(2) The former spouse must have been married to the same member or former member for at least 20 years, and at least 15, but less than 20 of those married years were creditable in determining the member's or former member's eligibility for retired or retainer pay.

(i) If the date of the final decree of divorce, dissolution, or annulment is before April 1, 1985, the former spouse is eligible only for care received on or after January 1, 1985, or the date of the divorce, dissolution, or annulment, whichever is later. Eligibility continues indefinitely unless affected by any of the conditions of paragraphs (b)(2)(i)(A) through (b)(2)(i)(E) of this section.

(ii) If the date of the final decree of divorce, dissolution or annulment is on or after April 1, 1985, but before September 29, 1988, the former spouse is eligible only for care received from the date of the decree of divorce, dissolution, or annulment until December 31, 1988, or for two years from the date of the divorce, dissolution, or annulment, whichever is later.

(iii) If the date of the final decree of divorce, dissolution, or annulment is on or after September 29, 1988, the former spouse is eligible only for care received within the 365 days (366 days in the case of a leap year) immediately following the date of the divorce, dissolution, or annulment.

(ii) Child. A dependent child is an unmarried child of a member or former member who has not reached his or her twenty-first (21st) birthday,

except an incapacitated adopted child meeting the requirements of paragraph (b)(2)(ii)(H)(2) of this section, and who bears one of the following relationships to a member or former member of one of the Uniformed Services:

(A) A legitimate child; or

(B) An adopted child whose adoption has been legally completed on or before the child's twenty-first (21st) birthday; or

(C) A legitimate stepchild; or

(D) An illegitimate child of a member or former member whose paternity/maternity has been determined judicially, and the member or former member directed to support the child; or

(E) An illegitimate child of a member or former member whose paternity/maternity has not been determined judicially, who resides with or in the home provided by the member or former member, and is or continues to be dependent upon the member or former member for over one-half of his or her support, or who was so dependent on the former member at the time of the former member's death; or

(F) An illegitimate child of a spouse of a member who resides with or in a home provided by the member and is, and continues

to be dependent upon the member for over one-half of his or her support; or

(G) An illegitimate child of a spouse of a former member who resides with or in a home provided by a former member or the former member's spouse at the time of death of the former member, and is, or continues to be, or was, dependent upon the former member for more than one-half of his or her support at the time of death; or

(H) An individual who falls into one of the following classes:

(1) A student. A child determined to be a member of one of the classes in paragraphs (b)(2)(ii)(A) through (b)(2)(ii)(G) of this section, who is not married, has passed his or her 21st birthday but has not passed his or her 23rd birthday, is dependent upon the member or former member for over 50 percent of his or her support or was dependent upon the member or former member for over 50 percent of his or her support on the date of the member's or former member's death, and is pursuing a full-time course of education in an institution of higher learning approved by the Secretary of Defense or the Department of Education (as appropriate) or by a state agency under 38 U.S.C. chapters 34 and 35.

Note: Courses of education offered by institutions listed in the "Education Directory," "Higher Education" or "Accredited Higher Institutions" issued periodically by the Department of Education meet the criteria approved by the Administering Secretary or the Secretary of Education. For determination of approval of courses offered by a foreign institution, by an institution not listed in either of the above directories, or by an institution not approved by a state agency pursuant to 38 U.S.C. chapters 34 and 35, a statement may be obtained from the Department of Education, Washington, D.C. 20202.

(2) An incapacitated child. A child determined to be a member of one of the classes in paragraphs (b)(2)(ii)(A) through (b)(2)(ii)(G) of this section, who is not married and is incapable of self-support because of a mental or physical disability that:

(i) Existed before the child's twenty-first (21st) birthday; or

(ii) Occurred between the ages of 21 and 23 while the child was enrolled in a full-time course of study in an institution of higher learning approved by the Administering Secretary or the Department of Education (see NOTE to paragraph (b)(2)(ii)(H)(2)(iii) of this section), and is or was at the time of the member's or former member's death dependent on the member or former

member for over one-half of his or her support; and

(iii) The incapacity is continuous. (If the incapacity significantly improves or ceases at any time, CHAMPUS eligibility cannot be reinstated on the basis of the incapacity, unless the incapacity recurs and the beneficiary is under age 21, or is under age 23 and is enrolled as a full-time student under paragraph (b)(2)(ii)(H)(2)(ii) of this section. If the child was not incapacitated after that date, no CHAMPUS eligibility exists on the basis of the incapacity. However, incapacitated children who marry and who subsequently become unmarried through divorce, annulment, or death of spouse, may be reinstated as long as they still meet all other requirements).

Note: An institution of higher learning is a college, university, or similar institution, including a technical or business school, offering post-secondary level academic instruction that leads to an associate or higher degree, if the school is empowered by the appropriate State education authority under State law to grant an associate, or higher, degree. When there is no State law to authorize the granting of a degree, the school may be recognized as an institution of higher learning if it is accredited for degree programs by a recognized accrediting agency. The term also shall include a hospital offering educational programs at the post-secondary level regardless of whether the hospital grants a post-

secondary degree. The term also shall include an educational institution that is not located in a State, that offers a course leading to a standard college degree, or the equivalent, and that is recognized as such by the Secretary of Education (or comparable official) of the country, or other jurisdiction, in which the institution is located (38 U.S.C. chapter 34, section 1661, and chapter 35, section 1701).

Courses of education offered by institutions listed in the "Education Directory," "Higher Education" or "Accredited Higher Institutions" issued periodically by the Department of Education meet the criteria approved by the Administering Secretary or the Secretary of Education. For determination of approval of courses offered by a foreign institution, by an institution not listed in either of the above directories, or by an institution not approved by a state agency pursuant to chapters 34 and 35 of 38 U.S.C., a statement may be obtained from the Department of Education, Washington, D.C. 20202.

(3) A child of a deceased reservist. A child, who is determined to be a member of one of the classes in paragraphs (b)(2)(ii)(A) through (b)(2)(ii)(G) of this section, of a reservist in a Uniformed Service who incurs or aggravates an injury, illness, or disease, during, or on the way to or from, active duty training for a period of 30 days or less or inactive duty training, and the reservist dies as a result of that specific injury, illness or disease.

(4) An unmarried person. An unmarried person placed in the home of a member or former member prior to adoption. To be a dependent child, the unmarried person must not have reached the age of 21 (or otherwise meets the requirements of a student or incapacitated child set out in paragraphs (b)(2)((ii)(H)(1) or (b)(2)(ii)(H)(2) of this section) and has been placed in the home of the member or former member by a recognized placement agency or by any other source authorized by State or local law to provide adoption placement, in anticipation of legal adoption by the member or former member.

(iii) Abused dependents. –

(A) Categories of abused dependents. An abused dependent may be either a spouse or a child. Eligibility for either class of abused dependent results from being either:

(1) The spouse (including a former spouse) or child of a member who has received a dishonorable or bad-conduct discharge, or dismissal from a Uniformed Service as a result of a court-martial conviction for an offense involving physical or emotional abuse of the spouse or child, or was administratively discharged as a result of such an offense. Until October 17, 1998, Medical benefits are limited to care related to the physical or emotional abuse and for a period of 12 months following the

member's separation from the Uniformed Service. On or after October 17, 1998, medical benefits can include all under the Basic Program and under the Extended Care Health Option for the period that the spouse or child is in receipt of transitional compensation under section 1059 of title 10 U.S.C.

(2) The spouse (including a former spouse) or child of a member or former member who while a member and as a result of misconduct involving abuse of the spouse or child has eligibility to receive retired pay on the basis of years of service terminated.

(B) Requirements for categories of abused dependents. –

(1) Abused spouse. As long as the spouse is receiving payments from the DoD Military Retirement Fund under court order, the spouse is eligible for health care under the same conditions as any spouse of a retired member. The abused spouse must:

(i) Under paragraph (b)(2)(iii)(A)(1) of this section, be a lawful husband or wife or a former spouse of the member; or

(ii) Under paragraph (b)(2)(iii)(A)(2) of this section, be a lawful husband or wife or a former spouse of the member or former member, and the spouse is receiving payments from the Department of Defense

Military Retirement Fund under 10 U.S.C. 1408(H0 pursuant to a court order; and

(A) Be a victim of the abuse; and

(B) Have been married to the member or former member at the time of the abuse; or

(C) Be the natural or adoptive parent of a dependent child of the member or former member who was the victim of the abuse.

(2) Abused child. The abused child must:

(i) Under paragraph (b)(2)(iii)(A)(1) of this section, be a dependent child of the member or former member.

(ii) Under paragraph (b)(2)(iii)(A)(2) of this section,

(A) Have been a member of the household where the abuse occurred; and

(B) Be an unmarried legitimate child, including an adopted child or stepchild of the member or former member; and

(C) Be under the age of 18; or

(D) Be incapable of self support because of a mental or physical incapacity that existed before becoming 18 years of age

and be dependent on the member or former member for over one-half of his or her support; or

(E) If enrolled in a full-time course of study in an institution of higher learning recognized by the Secretary of Defense (for the purpose of 10 U.S.C. 1408(h)), be under 23 years of age and be dependent on the member or former member for over one-half of his or her support.

(F) The dependent child is eligible for health care, regardless of whether any court order exists, under the same conditions as any dependent of a retired member.

(3) TAMP eligibles. A former member, including his or her dependents, who is eligible under the provisions of the Transitional Assistance Management Program as described in paragraph (e) of this § 199.3.

(iv) An unmarried person who is placed in the legal custody of a member or former member by a court of competent jurisdiction in the United States (or possession of the United States) for a period of at least 12 consecutive months. The unmarried person shall be considered a dependent of the member or former member under this section provided he or she otherwise meets the following qualifications:

(A) Has not reached the age of 21 unless he or she otherwise meets the requirements of a student set out in paragraph (b)(2)(ii)(H)(1) of this section or the requirements for being incapacitated as set out in paragraph (b)(2)(ii)(H)(2) of this section and the incapacitation occurred while he or she was a dependent of the member or former member through court ordered legal custody;

(B) Is dependent on the member or former member for over one-half of the person's support;

(C) Resides with the member or former member unless separated by the necessity of military service or to receive institutional care as a result of disability or incapacitation or under such other authorized circumstances; and,

(D) Is not a dependent of a member or former member under any other provision of law or regulation.

(3) Eligibility under TRICARE Senior Pharmacy Program. Section 711 of the National Defense Authorization Act for Fiscal Year 2001 (Public Law 106-398, 114 Stat. 1654) established the TRICARE Senior Pharmacy Program effective April 1, 2001. To be eligible for this program, a person is required to be:

(i) Medicare eligible, who is:

(A) 65 years of age or older; and

(B) Entitled to Medicare Part A; and

(C) Enrolled in Medicare Part B, except for a person who attained age 65 prior to April 1, 2001, is not required to enroll in Part B; and

(ii) Otherwise qualified under one of the following categories:

(A) A retired uniformed service member who is entitled to retired or retainer pay, or equivalent pay including survivors who are annuitants; or

(B) A dependent of a member of the uniformed services described in one of the following:

(1) A member who is on active duty for a period of more than 30 days or died while on such duty; or

(2) A member who died from an injury, illness, or disease incurred or aggravated while the member was:

(i) On active duty under a call or order to active duty of 30 days or less, on active duty for training, or on inactive duty training; or

(ii) Traveling to or from the place at which the member was to perform or had performed such active duty, active

duty for training, or inactive duty training.

Note to paragraph (b)(3)(ii)(B): Dependent under Section 711 of the National Defense Authorization Act for Fiscal Year 2001 includes spouse, unremarried widow/widower, child, parent/parent-in-law, unremarried former spouse, and unmarried person in the legal custody of a member or former member, as those terms of dependency are defined and periods of eligibility are set forth in 10 U.S.C. 1072(2).

(4) Medal of Honor recipients.

(i) A former member of the armed forces who is a Medal of Honor recipient and who is not otherwise entitled to medical and dental benefits has the same CHAMPUS eligibility as does a retiree.

(ii) Immediate dependents. CHAMPUS eligible dependents of a Medal of Honor Recipient are those identified in paragraphs (b)(2)(i) of this section (except for former spouses) and (b)(2)(ii) of this section (except for a child placed in legal custody of a Medal of Honor recipient under (b)(2)(ii)(H)(4) of this section).

(iii) Effective date. The CHAMPUS eligibility established by paragraphs (b)(4)(i) and (ii) of this section is applicable to health care services provided on or after October 30, 2000.

(5) Reserve Component Members Issued Delayed-Effective-Date Orders.

(i) Member. A member of a reserve component of the armed forces who is ordered to active duty for a period of more than 30 consecutive days in support of a contingency operation under a provision of law referred to in section 101(a)(13)(B) of Title 10, United States Code, that provides for active-duty service to begin on a date after the date of the issuance of the order.

(ii) Dependents. CHAMPUS eligible dependents under this paragraph (b)(5) are those identified in paragraphs (b)(2)(i) (except former spouses) and (b)(2)(ii) of this section.

(iii) Effective date. The eligibility established by paragraphs (b)(5)(i) and (ii) of this section shall begin on or after November 6, 2003, and shall be effective on the later of the date that is:

(A) The date of issuance of the order referred to in paragraph (b)(5)(i) of this section; or

(B) 90 days before the date on which the period of active duty is to begin.

(iv) Termination date. The eligibility established by paragraphs (b)(5)(i) and (ii) of this section ends upon entry of the member onto active duty (at which time CHAMPUS eligibility for the dependents of the member is established under paragraph (b)(2) of this section) or upon cancellation or amendment of the orders referred

to in paragraph (b)(5)(i) of this section such that they no longer meet the requirements of that paragraph (b)(5)(i).

(c) Beginning dates of eligibility.

(1) Beginning dates of eligibility depend on the class to which the individual belongs and the date the individual became a member of the class. Those who join after the class became eligible attain individual eligibility on the date they join.

(2) Beginning dates of eligibility for each class of spouse (excluding spouses who are victims of abuse and eligible spouses of certain deceased reservists) are as follows:

(i) A spouse of a member for:

(A) Medical benefits authorized by the Dependents' Medical Care Act of 1956, December 7, 1956;

(B) Outpatient medical benefits under the Basic Program, October 1, 1966;

(C) Inpatient medical benefits under the Basic Program and benefits under the Extended Care Health Option, January 1, 1967;

(ii) A spouse of a former member:

(A) For medical benefits under the Basic Program, January 1, 1967.

(B) Ineligible for benefits under the Extended Care Health Option.

(iii) A former spouse:

(A) For medical benefits under the Basic Program, dates of beginning eligibility are as indicated for each category of eligible former spouse identified within paragraph (b)(2)(i) of this section.

(B) Ineligible for benefits under the Extended Care Health Option.

(3) Beginning dates of eligibility for spouses who are victims of abuse (excluding spouses who are victims of abuse of certain deceased reservists) are as follows:

(i) An abused spouse meeting the requirements of paragraph (b)(2)(iii)(A)(1) of this section, including an eligible former spouse:

(A) For medical and dental care for problems associated with the physical or emotional abuse under the Basic Program for a period of up to one year (12 months) following the person's separation from the Uniformed Service, November 14, 1986.

(B) For all medical and dental benefits under the Basic Program for the period that the spouse is in receipt of transitional compensation under section 1059 of title 10 U.S.C., October 17, 1998.

(C) For medical and dental care for problems associated with the physical or emotional abuse under the Extended Care Health Option for a period up to one year (12 months) following the person's separation from the Uniformed Service, November 14, 1986.

(D) For all medical and dental benefits described in section 199.5 for the period that the spouse is in receipt of transitional compensation under section 1059 of title 10 U.S.C., October 17, 1998.

(ii) An abused spouse meeting the requirements of paragraphs (b)(2)(iii)(A)(2) of this section, including an eligible former spouse:

(A) For all benefits under the CHAMPUS Basic Program, October 23, 1992.

(B) Ineligible for benefits under the Extended Care Health Option.

(4) Beginning dates of eligibility for spouses of certain deceased reservists, including spouses who are victims of abuse of certain deceased reservists, are as follows:

(i) A spouse meeting the requirements of paragraph (b)(2)(i) of this section, including an eligible former spouse:

(A) For benefits under the Basic Program, November 14, 1986.

(B) Ineligible for benefits under the Extended Care Health Option.

(ii) An abused spouse of certain deceased reservists, meeting the requirements of paragraphs (b)(2)(iii) of this section, including an eligible former spouse, for the limited benefits and period of eligibility described in paragraphs (b)(2)(iii) of this section:

(A) For benefits under the Basic Program, November 14, 1986.

(B) For benefits under the Extended Care Health Option, November 14, 1986.

(iii) An abused spouse of certain deceased reservists, including an eligible former spouse, meeting the requirements of paragraphs (b)(2)(iii) of this section:

(A) For benefits under the Basic Program, October 23, 1992.

(B) Ineligible for benefits under the Extended Care Health Option.

(5) Beginning dates of eligibility for each class of dependent children, (excluding dependent children of certain deceased reservists, abused children and incapacitated children whose incapacity occurred between the ages of 21 and 23 while enrolled in a full-time course of study in an institution of higher learning), are as follows:

(i) Legitimate child, adopted child, or legitimate stepchild of a member, for:

(A) Medical benefits authorized by the Dependents' Medical Care Act of 1956, December 7, 1956;

(B) Outpatient medical benefits under the Basic Program, October 1, 1966;

(C) Inpatient medical benefits under the Basic Program and benefits under the Extended Care Health Option, January 1, 1967;

(ii) Legitimate child, adopted child or legitimate stepchild of former members:

(A) For medical benefits under the Basic Program, January 1, 1967.

(B) Ineligible for benefits under the Extended Care Health Option.

(iii) Illegitimate child of a male or female member or former member whose paternity/maternity has been determined judicially and the member or former member has been directed to support the child, for:

(A) All benefits for which otherwise entitled, August 31, 1972.

(B) Extended Care Health Option benefits limited to dependent children of members only, August 31, 1972.

(iv) Illegitimate child of:

(A) A male member or former member whose paternity has not been determined judicially:

(B) A female member or former member who resides with, or in a home provided by the member or former member, or who was residing in a home provided by the member or former member at the time of the member's or former member's death, and who is or continues to be dependent on the member for over one-half of his or her support, or was so dependent on the member or former member at the time of death;

(C) A spouse of a member or former member who resides with or in a home provided by the member or former member, or the parent who is the spouse of the member or former member or was the spouse of a member or former member at the time of death, and who is and continues to be dependent upon the member or former member for over one-half of his or her support, or was so dependent on the member or former member at the time of death; for:

(1) All benefits for which otherwise eligible, January 1, 1969.

(2) Extended Care Health Option limited to dependent children of members only, January 1, 1969.

(6) Beginning dates of eligibility for children of certain deceased reservists who meet the requirements of paragraph (b)(2)(ii)(H)(3) of this section, excluding incapacitated children who meet the requirements of paragraph (b)(2)(ii)(H)(2) of this section, for:

(i) Benefits under the Basic program, November 14, 1986.

(ii) Not eligible for benefits under the Extended Care Health Option.

(7) Beginning dates of eligibility for children who are victims of abuse, including incapacitated children who meet the requirements of paragraph (b)(2)(ii)(H)(2) of this section are as follows:

(i) An abused child meeting the requirements of paragraph (b)(2)(iii)(A)(1) of this section:

(A) Medical and dental care for problems associated with the physical or emotional abuse under the Basic Program for a period of up to one year (12 months) following the person's separation from the Uniformed Service, November 14, 1986.

(B) For all medical and dental benefits under the Basic Program for the period that the child is in receipt of transitional compensation under section 1059 of title 10 U.S.C., October 17, 1998.

(C) Medical and dental care for problems associated with the physical or emotional abuse under the Extended Care Health Option for a period up to one year (12 months) following the person's separation from the Uniformed Service, November 14, 1986.

(D) For all medical and dental benefits described in section 199.5 for the period that the child is in receipt of transitional compensation under section 1059 of title 10 U.S.C., October 17, 1998.

(ii) An abused child meeting the requirements of paragraphs (b)(2)(iii)(A)(2) of this section:

(A) For all benefits under the CHAMPUS Basic Program, October 23, 1992.

(B) Ineligible for benefits under the Extended Care Health Option.

(8) Beginning dates of eligibility for incapacitated children who meet the requirements of paragraph (b)(2)(ii)(H)(2) of this section, whose incapacity occurred between the ages of 21 and 23 while enrolled in a full-time course of study in an institution of higher learning approved by the Administering Secretary or the Department of Education, and, are or were at the time of the member's or former member's death, dependent on the member or former member for over one-half of their support, for:

(i) All benefits for which otherwise entitled, October 23, 1992.

(ii) Extended Care Health Option benefits limited to children of members only, October 23, 1992.

(9) Beginning dates of eligibility for a child who meets the requirements of paragraph (b)(2)(ii)(H)(4) and:

(i) Has been placed in custody by a court:

(A) All benefits for which entitled, July 1, 1994.

(B) Extended Care Health Option benefits limited to children of members only, July 1, 1994.

(ii) Has been placed in custody by a recognized adoption agency:

(A) All benefits for which entitled, October 5, 1994.

(B) Extended Care Health Option benefits limited to children of members only, October 5, 1994.

(iii) Has been placed in the home of a member by a placement agency or by any other source authorized by State or local law to provide adoption placement, in anticipation of the legal adoption of the member:

(A) All benefits for which entitled, January 6, 2006.

(B) Extended Care Health Option benefits limited to children of members only, January 6, 2006.

(10) Beginning dates of eligibility for a retiree for:

(i) Medical benefits under the Basic Program January 1, 1967.

(ii) Retirees and their dependents are not eligible for benefits under the Extended Care Health Option.

(d) Dual eligibility. Dual eligibility occurs when a person is entitled to benefits from two sources. For example, when an active duty member is also the dependent of another active duty member, a retiree, or a deceased active duty member or retiree, dual eligibility, that is, entitlement to direct care from the Uniformed Services medical care system and CHAMPUS is the result. Since the active duty status is primary, and it is the intent that all medical care be provided an active duty member through the Uniformed Services medical care system, CHAMPUS eligibility is terminated as of 12:01 a.m. on the day following the day the dual eligibility begins. However, any dependent children in a marriage of two active duty persons or of an active duty member and a retiree, are CHAMPUS eligible in the same manner as dependent children of a marriage involving only one CHAMPUS sponsor. Should a spouse or dependent who has dual eligibility leave

active duty status, that person's CHAMPUS eligibility is reinstated as of 12:01 a.m. of the day active duty ends, if he or she otherwise is eligible as a dependent of a CHAMPUS sponsor.

Note: No CHAMPUS eligibility arises as the result of the marriage of two active duty members.

(e) Eligibility under the Transitional Assistance Management Program (TAMP).

(1) A member of the armed forces is eligible for transitional health care if the member is:

(i) A member who is involuntarily separated from active duty.

(ii) A member of a Reserve component who is separated from active duty to which called or ordered in support of a contingency operation if the active duty is active duty for a period of more than 30 consecutive days.

(iii) A member who is separated from active duty for which the member is involuntarily retained under 10 U.S.C. 12305 in support of a contingency operation; or

(iv) A member who is separated from active duty served pursuant to a voluntary agreement of the member to remain on active duty for a period of less than 1 year in support of a contingency operation.

(2) A spouse (as described in paragraph (b)(2)(i) of this section except former spouses) and child (as described in paragraph (b)(2)(ii) of this section) of a member described in paragraph (e)(1) of this section is also eligible for TAMP benefits under TRICARE.

(3) TAMP benefits under TRICARE begin on the day after the member is separated from active duty, and, if such separation occurred on or after November 6, 2003, and end 180 days after such date. TRICARE benefits available to both the member and eligible family members are generally those available to family members of members of the uniformed services under this Part. Each branch of service will determine eligibility for its members and eligible family members and provide data to DEERS.

(f) Changes in status which result in termination of CHAMPUS eligibility. Changes in status which result in a loss of CHAMPUS eligibility as of 12:01 a.m. of the day following the day the event occurred, unless otherwise indicated, are as follows:

(1) Changes in the status of a member.

(i) When an active duty member's period of active duty ends, excluding retirement or death.

(ii) When an active duty member is placed on desertion status (eligibility is reinstated when the active duty member is removed from desertion status and returned to military control).

Note: A member serving a sentence of confinement in conjunction with a sentence of punitive discharge is still considered on active duty until such time as the discharge is executed.

(2) Changes in the status of a retiree.

(i) When a retiree ceases to be entitled to retired, retainer, or equivalent pay for any reason, the retiree's dependents lose their eligibility unless the dependent is otherwise eligible (e.g., some former spouses, some dependents who are victims of abuse and some incapacitated children as outlined in paragraph (b)(2)(ii)(H)(2) of this section).

(ii) A retiree also loses eligibility when no longer entitled to retired, retainer, or equivalent pay.

Note: A retiree who waives his or her retired, retainer or equivalent pay is still considered a retiree for the purposes of CHAMPUS eligibility.

(3) Changes in the status of a dependent.

(i) Divorce, except for certain classes of former spouses as provided in paragraph (b)(2)(i) of this section and the member or former member's own children (i.e., legitimate, adopted, and judicially determined illegitimate children).

Note: An unadopted stepchild loses eligibility as of 12:01 a.m. of the day following the day the divorce becomes final.

(ii) Annulment, except for certain classes of former spouse as provided in paragraph (b)(2)(i) of this section and the member or former member's own children (i.e., legitimate, adopted, and judicially determined illegitimate children).

Note: An unadopted stepchild loses eligibility as of 12:01 a.m. of the day following the day the annulment becomes final.

(iii) Adoption, except for adoptions occurring after the death of a member or former member.

(iv) Marriage of a child, except when the marriage is terminated by death, divorce, or annulment before the child is 21 or 23 if an incapacitated child as provided in paragraph (b)(2)(ii)(H)(2) of this section.

(v) Marriage of a widow or widower, except for the child of the widow or widower who was the stepchild of the deceased member or former member at the time of death. The stepchild continues CHAMPUS eligibility as other classes of dependent children.

(vi) Attainment of entitlement to hospital insurance benefits (Part A) under Medicare except as provided in paragraphs (b)(3), (f)(3)(vii), (f)(3)(viii), and (f)(3)(ix) of this section. (This also applies to individuals living outside the United States where Medicare benefits are not available.)

(vii) Attainment of age 65, except for dependents of active duty members, beneficiaries not entitled to part A of Medicare, beneficiaries entitled to Part A of Medicare who have enrolled in Part B of Medicare, and as provided in paragraph (b)(3) of this section. For those who do not retain CHAMPUS, CHAMPUS eligibility is lost at 12:01 a.m. on the first day of the month in which the beneficiary becomes entitled to Medicare.

Note: If the person is not eligible for Part A of Medicare, he or she must file a Social Security Administration, "Notice of Disallowance" certifying to that fact with the Uniformed Service responsible for the issuance of his or her identification card so a new card showing CHAMPUS eligibility can be issued. Individuals entitled only to supplementary medical insurance (Part B) of Medicare, but not Part A, or Part A through the Premium HI provisions (provided for under the 1972 Amendments to the Social Security Act) retain eligibility under CHAMPUS (refer to § 199.8 for additional information when a double coverage situation is involved).

(viii) End stage renal disease. All beneficiaries, except dependents of active duty members, lose their CHAMPUS eligibility when Medicare coverage becomes available to a person because of chronic renal disease unless the following conditions have been met. CHAMPUS eligibility will continue if:

(A) The individual is under 65 years old;

(B) The individual became eligible for Medicare under the provisions of 42 U.S.C. 426-1(a);

(C) The individual is enrolled in Part B of Medicare; and

(D) The individual has applied and qualified for continued CHAMPUS eligibility through the Defense Enrollment Eligibility Reporting System (DEERS).

(ix) Individuals with certain disabilities. Each case relating to Medicare eligibility resulting from being disabled requires individual investigation. All beneficiaries except dependents of active duty members lose their CHAMPUS eligibility when Medicare coverage becomes available to a disabled person unless the following conditions have been met. CHAMPUS eligibility will continue if:

(A) The individual is under 65 years old;

(B) The individual became eligible for Medicare under the provisions of 42 U.S.C. 426(b)(2);

(C) The individual is enrolled in Part B of Medicare; and

(D) The individual has applied and qualified for continued CHAMPUS eligibility through the Defense Enrollment Eligibility Reporting System (DEERS).

(x) Disabled students, that is children age 21 or 22, who are pursuing a full-time course of higher education and who, either during the school year or between semesters, suffer a disabling illness or injury with resultant inability to resume attendance at the institution remain eligible for CHAMPUS medical benefits for 6 months after the disability is removed or until the student passes his or her 23rd birthday, whichever occurs first. However, if recovery occurs before the 23rd birthday and there is resumption of a full-time course of higher education, CHAMPUS benefits can be continued until the 23rd birthday. The normal vacation periods during an established school year do not change the eligibility status of a dependent child 21 or 22 years old in a full time student status. Unless an incapacitating condition existed before, and at the time of, a dependent child's 21st birthday, a dependent child 21 or 22 years old in student status does not have eligibility and may not qualify for eligibility under the requirements related to mental or physical incapacity as described in paragraph (b)(2)(ii)(H)(2) of this section.

(g) Reinstatement of CHAMPUS eligibility. Circumstances which result in reinstatement of CHAMPUS eligibility are as follows:

(1) End Stage renal disease. Unless CHAMPUS eligibility has been continued under paragraph (f)(3)(viii) of the section, when Medicare eligibility ceases for end-stage renal disease patients, CHAMPUS eligibility resumes if the person is

otherwise still eligible. He or she is required to take action to be reinstated as a CHAMPUS beneficiary and to obtain a new identification card.

(2) Disability. Some disabilities are permanent, others temporary. Each case must be reviewed individually. Unless CHAMPUS eligibility has been continued under paragraph (f)(3)(ix) of this section, when disability ends and Medicare eligibility ceases, CHAMPUS eligibility resumes if the person is otherwise still eligible. Again, he or she is required to take action to obtain a new CHAMPUS identification card.

(h) Determination of eligibility status. Determination of an individual's eligibility as a CHAMPUS beneficiary is the primary responsibility of the Uniformed Service in which the member or former member is, or was, a member, or in the case of dependents of a NATO military member, the Service that sponsors the NATO member. For the purpose of program integrity, the appropriate Uniformed Service shall, upon request of the Director, OCHAMPUS, review the eligibility of a specific person when there is reason to question the eligibility status. In such cases, a report on the results of the review and any action taken will be submitted to the Director, OCHAMPUS, or a designee.

(i) Procedures for determination of eligibility. Procedures for the determination of eligibility are prescribed within the Department of Defense

Instruction 1000.13 available at local military facilities personnel offices.

(j) CHAMPUS procedures for verification of eligibility.

(1) Eligibility for CHAMPUS benefits will be verified through the Defense Enrollment Eligibility Reporting System (DEERS) maintained by the Uniformed Services, except for abused dependents as set forth in paragraph (b)(2)(iii) of this section. It is the responsibility of the CHAMPUS beneficiary, or parent, or legal representative, when appropriate, to provide the necessary evidence required for entry into the DEERS file to establish CHAMPUS eligibility and to ensure that all changes in status that may affect eligibility be reported immediately to the appropriate Uniformed Service for action.

(2) Ineligibility for CHAMPUS benefits may be presumed in the absence of prescribed eligibility evidence in the DEERS file.

(3) The Director, OCHAMPUS, shall issue guidelines as necessary to implement the provisions of this section.

OFFICE OF PERSONNEL MANAGEMENT FEDERAL EMPLOYEES HEALTH BENEFITS ACQUISITION REGULATIONS

48 C.F.R. 1602.170-2. Community rate

(a) Community rate means a rate of payment based on a per member per month capitation rate or its equivalent that applies to a combination of the subscriber groups for a comprehensive medical plan carrier. References in this subchapter to "a combination of cost and price analysis" relating to the applicability of policy and contract clauses refer to comprehensive medical plan carriers using community rates.

(b) Adjusted community rate means a community rate which has been adjusted for expected use of medical resources of the FEHBP group. An adjusted community rate is a prospective rate and cannot be retroactively revised to reflect actual experience, utilization, or costs of the FEHBP group.

AMICUS CURIAE BRIEF

SUPREME COURT, U.S.
FILED
DEC 18 2009
OFFICE OF THE CLERK

No. 09-38

In the
Supreme Court of the United States

HEALTH CARE SERVICE CORPORATION,
Petitioner,
v.
JULI A. POLLITT and MICHAEL A. NASH,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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BRIEF FOR THE AMICI CURIAE ASSOCIATION OF FEDERAL HEALTH ORGANIZATIONS AND AMERICA'S HEALTH INSURANCE PLANS, INC. IN SUPPORT OF PETITIONER

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INTEREST OF *AMICUS CURIAE*[1]

The Association of Federal Health Organizations ("AFHO") is a trade association whose regular membership is composed of nine employee organizations which are the carriers of the respective Federal Employees Health Benefits Act ("FEHBA") health benefit plans which their organizations sponsor. *See* 5 U.S.C. §§ 8901(6), (8), 8903(3).[2] Collectively, approximately 1,200,000 federal and postal employees and annuitants, including their dependents, are enrolled in AFHO member FEHB plans. *See* U.S. Office of Personnel Management, Federal Civilian Workforce Statistics, The Fact Book at 82 (2007).

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[1] Counsel for the parties to this case have filed letters with the Clerk of the Court consenting, in a global manner, to the filing of all amicus briefs supporting either side in this case. *See* Supreme Court Rule 37.3(a). No counsel for a party authored this brief in whole or in part, and no person or entity, other than the *amici curiae*, its regular members, or its counsel, made a monetary contribution to the preparation or submission of this brief.

[2] AFHO's regular members are carriers of the following FEHB plans: the American Postal Workers Union Health Plan, the Association Benefit Plan, the Foreign Service Benefit Plan, the Government Employees Health Association Benefit Plan, the Mail Handlers Benefit Plan, the National Association of Letter Carriers Health Benefit Plan, the Panama Canal Area Benefit Plan, the Rural Letter Carriers Benefit Plan, and the SAMBA Health Benefits Plan. The Blue Cross Blue Shield Association is an associate member of AFHO, but it did not make a monetary contribution to the preparation or submission of this brief.

America's Health Insurance Plans, Inc. ("AHIP") is a trade association representing the private health plan and insurer community. AHIP's mission is to advance healthcare quality and affordability through leadership in the healthcare community, advocacy, and the provision of services to its members. AHIP represents nearly 1,300 member companies that insure benefits, including health, pharmaceutical, long term care, disability, and supplemental coverage to more than 200 million Americans. Many AHIP members are FEHB plan carriers.

This case presents the issue of whether the FEHBA completely preempts -- and therefore makes removable to federal court -- a state court suit challenging enrollment and health benefits determinations that are subject to the exclusively federal remedial scheme established in FEHBA. Resolution of this issue will impact the administration and cost of the amici member plans in the same manner as it will the government wide service benefit plan of which the Petitioner is an integral part. Because the case presents an important issue of significant and direct impact on amici, they respectfully request that the Court entertain their views as to why the issues presented should be resolved in the Petitioner's favor.

SUMMARY OF ARGUMENT

Congress has created the FEHBA in the exercise of its Constitutional authority over federal employee compensation. Since at least 1975, Congress and the U.S. Office of Personnel Management ("OPM"), the federal agency that Congress made responsible for

the FEHB Program, have developed an exclusive, comprehensive federal remedy that federal employees must use to resolve FEHBA enrollment and benefit disputes.

Respondents filed a lawsuit against Petitioner in Illinois State court over FEHBA enrollment and benefit issues. In *Empire Healthchoice Assurance Inc. v. McVeigh*, 547 U.S. 677 (2006), this Court recognized that such cases must land in federal court. This Court should extend the complete preemption doctrine to this FEHBA case as it previously ruled in the analogous context of enrollment and benefit claim lawsuits under ERISA.

FEHB participants and the overall FEHB program objectives are best served by a nationally uniform, comprehensive, and efficient process for handling enrollment and benefit determinations, rather than submitting such decisions to a complex variety of state administrative and judicial processes, as Congress intended.

Alternatively, Petitioner was entitled to remove the case from state to federal court under the federal officer removal statute, 28 U.S.C. § 1442(a)(1). This case meets the three jurisdictional prerequisites for removal – Petitioner, a closely supervised federal contractor, was acting under a federal officer; the acts of which Respondents complained to the State Court were undertaken by Petitioner in accordance with its federal contract obligations, and a colorable federal defense exists based on the exclusive federal remedy and the FEHBA, 5 U.S.C. § 8902(m)(1).

ARGUMENT

THE RESPONDENTS' CASE WAS REMOVABLE TO FEDERAL COURT BASED ON THE COMPLETE PREEMPTION DOCTRINE AND THE FEDERAL OFFICER REMOVAL STATUTE

1. Nature of the FEHB Program

Congress enacted the FEHBA, 5 U.S.C. §§ 8901 – 8914, in 1959. Congress thereby added to the then-existing federal employee compensation package a voluntary group health insurance program, the cost of which was to be shared by the federal government, as the employer, and the employees who decide to enroll in the FEHB Program. Congress established the FEHB Program to assure "that the federal government can compete in the recruitment and retention of competent personnel." *American Federation of Government Employees v. Devine*, 525 F. Supp. 250, 252 n. 2 (D.D.C. 1981), citing S. Rep. No 86-468, at 1-2 (1959); H.R. Rep. No. 86-957, at 1-2 (1959). Approximately eight million federal and postal employees, retirees, and their dependents currently are covered under the FEHB Program. *See Hearing on FEHBP's Prescription Drug Benefits Before the House Subcommittee on Federal Workforce*, at 1 (June 24, 2009) (statement of Nancy Kichak, Associate Director, OPM) (*available at* http://www.opm.gov/News_events/Congress/Testimony/index.asp).

As is the case with any legislation governing federal employee compensation, FEHBA's enactment was "historically and constitutionally within Congress' power" to the exclusion of state or local government authority. *Puglisi v. United States*, 564 F.2d 403, 409 (Ct. Cl. 1977), *cert denied*, 435 U.S. 968 (1978); *see also Bush v. Lucas*, 462 U.S. 367 (1983), *aff'g*, 647 F.2d 573 (5th Cir. 1981); *Kizas v. Webster*, 707 F.2d 524, 536 (D.C. Cir. 1983), *cert. denied*, 464 U.S. 1042 (1984). Congress' exclusive authority in this area stems from the appointment of inferior officers clause and the necessary and proper clause of the U.S. Constitution. U.S. Const. art. II, § 2, cl. 2 and art. I, § 8, cl. 18. *See, e.g., United States v. Will*, 449 U.S. 200 (1980); *Atkins v. United States*, 556 F. 2d 1028, 1060 (Ct. Cl. 1977), *cert. denied*, 434 U.S. 1009 (1978)

Rather than establish a program under which the government assumed the risk of providing health insurance coverage to its employees, Congress chose to assign that task to a variety of private sector "carriers" under a specialized federal procurement arrangement. Under this arrangement, the U.S. Office of Personnel Management ("OPM") is granted broad responsibility to contract for four types of plans: one Government wide service benefit plan (in which Petitioner participates); one Government wide indemnity benefit plan; employee organization plans (in which class the AFHO regular member plans fall), and comprehensive medical plans (in which class several AHIP member plans fall). 5 U.S.C. §§ 8902, 8903, 8903a. Thus, FEHB plan carriers assist OPM in fulfilling a basic governmental task. *See*

Watson v. Philip Morris Cos., 551 U.S. 142, 143 (2007).

FEHBA creates a comprehensive regulatory scheme for establishing and operating FEHB plans. FEHBA specifies who may enroll for coverage and defines eligible family members. 5 U.S.C. §§ 8901, 8906, 8908, 8914. FEHBA expressly authorizes OPM to determine enrollment for coverage, *id.* §§ 8902(f), 8905, 8908, and sets standards for the termination of coverage, *id.* § 8902(g), (h). It further provides for certain extensions of coverage and for carriers to offer conversion coverage. *Id.* §§ 8902(g), (h), 8905(c), 8905a.

FEHBA establishes qualifications for FEHB plan carriers, *id.* § 8901 (7), (8), and it empowers OPM to set and enforce minimum standards for health benefit plans and their carriers, *id.* § 8902(e). It establishes benefit types and levels, and it prescribes the method for setting plan rates. *Id.* § 8902(d), (i) and 8904.

FEHBA requires the government wide plans, including the plan in which Petitioner participates, and the employee organizations plans, to be retrospectively experience rated. 5 U.S.C. § 8902(i). As experience rated plans, the price for each contract is based on their past "experience" which includes enrollees' actual paid claims, administrative expenses (such as benefits litigation expenses), retentions, and estimated claims incurred but not reported, adjusted for benefit modifications, utilization trends, and economic trends. 48 C.F.R. §§ 1602.170-7, 1652.216–71(b)(2)(iii).

FEHBA provides a generous government contribution toward the cost of coverage, *id.* § 8906, for the establishment of a dedicated fund in the U.S. Treasury for handling all Program funds, and for the establishment and OPM control of FEHB plan contingency and FEHB Program administration reserves. *Id.* § 8909.

FEHBA states that OPM must approve each health benefit plan contract and each plan's "detailed statement of benefits," which must include those "benefit maximums, limitations, exclusions, and definitions that OPM considers necessary or desirable." 5 U.S.C. § 8902(a), (d). It requires that every contract contain a provision requiring the carrier to pay any claim for a contract benefit at OPM's direction. *Id.* § 8902(j). It requires that each plan enrollee shall be issued "an appropriate document" describing the plan's benefits, claims procedures, and other principal provisions affecting the enrollee and any eligible family members. *Id.* § 8907.

FEHBA mandates that the plan contract shall require the carrier to make periodic reports on plan financing to OPM and to cooperate with the audit of plan records by OPM representatives and the Government Accountability Office. 5 U.S.C. § 8910.

FEHBA renders OPM responsible for policing a carrier's performance of its FEHB plan contract. 5 U.S.C. §§ 8902(e), 8913(a), For example, "[a] pattern of poor conduct or evidence of misconduct" -- such as "[u]sing fraudulent or unethical business or health

care practices or otherwise displaying a lack of business integrity or honesty" -- "is cause for OPM to withdraw approval of the carrier" and to "effect corrective action." 48 C.F.R. § 1609.7001(c)(2), (d). OPM may take remedial action in the event of a "significant event" impacting the carrier or its underwriter. *Id.* §§ 1622.103–70, 1652.222–70. OPM further is responsible for policing the conduct of the healthcare providers who treat FEHB plan enrollees. 5 U.S.C. § 8902a.

In sum, FEHBA places the FEHB Program under OPM's direct and extensive control, and it empowers OPM to make such contracts and to prescribe such regulations as it deems necessary to carry out for the FEHBA's purposes. *Id.* § 8913. The FEHBA expressly requires OPM to make regulations that "provide for the beginning and ending dates of coverage of employees, annuitants, members of their families, and former spouses under health benefit plans." *Id.* § 8913(c).

OPM has promulgated those comprehensive regulations at 5 C.F.R. Part 890 and 48 C.F.R. Ch. 16. Of particular note for purposes of this case are OPM's regulations governing family member enrollment and the resolution of FEHBP enrollment and benefit claim disputes. 5 C.F.R. §§ 890.103, 890.104, 890.105, 890.107, 890.302; 48 C.F.R. §§ 1604.7101, 1652.204–72. Such regulations promulgated by a federal agency pursuant to an act of Congress carry with them the force of law. *See Chevron U.S.A. Inc. v. Natural Resources Defense Council*, 467 U.S. 837, 843-44 (1984).

Federal employees, including the Respondent, Juli Pollitt, have the unqualified right, if they desire, to enroll in the FEHB Program on a self-only or self and family basis through their employing agency. They do so by following the OPM approved process. *See* 5 U.S.C. § 8905(a): 5 C.F.R. §§ 890.101(a), 890.102, 890.301. Consequently, they obtain that coverage solely by enrolling in the statutory FEHBA fringe benefit program offered by their employer, the federal government. *See Zucker v. United States*, 758 F.2d 637, 640 (Fed. Cir. 1985):

> [F]ederal workers serve by appointment, and their rights are therefore a matter of "legal status" even where compacts are made. *Kania v. United States*, 650 F.2d 264, 268, *cert. denied*, 454 U.S. 895 (1981). In other words, their entitlement to retirement benefits must be determined by reference to the statute and regulations governing these benefits, rather than to ordinary contract principles. *United States v. Larionoff*, 431 U.S. [864] at 869 [1977)].

They thereby subscribe to the statement of benefits approved by OPM and submit to OPM's regulatory requirements. In so doing, they further agree with the federal government to share in the cost of that benefit through payroll deductions in an amount established by the FEHBA, 5 U.S.C. § 8906(c), (d).

2. Development of FEHBA Preemption of State Law and an Exclusive Federal Remedy

In 1975, the Comptroller General advised Congress that because the states were becoming increasingly "active in establishing and enforcing health insurance requirements," Congress should "clarify whether State requirements should be permitted to alter terms of contracts negotiated pursuant to the [FEHBA]. S. Rep. No. 95-903, at 9 (1978), *reprinted in* 1978 U.S.C.C.A.N. 1413, 1420. The Civil Service Commission ("CSC"), OPM's predecessor as FEHB Program administrator, shared that view. In reliance on its general counsel's opinion, CSC took the position that:

> The Supremacy Clause [of the U.S. Constitution, art. VI, § 2] creates an immunity from state interference of federal operations. The principles underlying the need for national uniformity in the administration of Federal functions operate to supersede conflicts arising from State laws and apply with equal regard to the Commission's administration of the [FEHBA]. The McCarran-Ferguson Act by its terms and the interpretations of the courts in no way diminishes the supremacy of the [FEHBA] over State laws. If the Commission is to have a free hand it needs to administer the [FEHBA], no other conclusion can be reached.

Id. at 8. Concerned that "[t]hese [State] laws in effect presented serious problems from the standpoint of the uniformity of benefits under the

Program," *id.* at 7, CSC urged Congress to insure "that the [FEHB] Program – a program established by an Act of Congress – should not be subject to alteration or regulation by State legislatures or State insurance boards." H.R. Rep. No. 95-282, 1, 4 (1977).

Congress specifically recognized that imposition of State law requirements on FEHBA contracts would result in:

> Increased premium costs to both the Government and enrollees, and
>
> A lack of uniformity of benefits for enrollees in the same plan which would result in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States.

Id. *See also* S. Rep. No. 95-903, *supra*, at 2, 4, 9. Congress also recognized that, absent federal legislation affirming federal supremacy in this area,

> Enforcement of this preemption policy w[ould] almost inevitably lead to time consuming and costly litigation with the States until [the CSC's] position is upheld . . . .

H.R. Rep. No. 95-282, *supra*, at 3.

In 1978, Congress amended FEHBA to include 5 U.S.C. § 8902(m)(1), which read as follows:

> The provisions of any contract under this chapter which relate to the nature or extent of

> coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with contractual provisions.

As the legislative history confirms, Congress did not regard this provision as a statute which would restrict the reach of otherwise applicable state law. To the contrary, Congress recognized that the FEHBA, as a federal personnel statute, was from the outset beyond the reach of State law. Section 8902(m)(1) thus was added to FEHBA to state that proposition explicitly, and thereby hopefully to save the litigation costs required to affirm it judicially.[3]

Unfortunately, the enactment of Section 8902(m)(1) did not entirely avoid FEHBA litigation. Over the course of the next fifteen years, the lower federal courts established that the FEHBA

- required federal employees to exhaust their available administrative remedies before bringing a lawsuit against a carrier over a benefit dispute;

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[3] The legislative history of this provision establishes that Congress elected to permit the States to regulate the operations of FEHBA plans in two respects – state taxation of health insurance company premiums and maintenance of state statutory reserves for those companies. H.R. Rep. No. 95-282, *supra*, at 4-5. In 1990, Congress added Section 8909(f) to the FEHBA. This provision severely restricted future state taxation of FEHBA plans.

- limited judicial review to the OPM decision on the disputed claim rendered pursuant to 5 C.F.R. § 890.105, and
- preempted state law based actions against carriers, such as claims for bad faith torts or intentional infliction of emotional distress because those claims were inextricably intertwined with the benefit disputes.

See, e.g., Nesseim v. Mail Handlers Benefit Plan, 995 F.2d 804 (8th Cir. 1993); *Harris v. Mutual of Omaha Companies*, 992 F.2d 706 (7th Cir. 1993); *Caudill v. Blue Cross and Blue Shield*, 999 F.2d 74 (4th Cir. 1993); *Kennedy v. Empire Blue Cross & Blue Shield*, 989 F.2d 588 (2nd Cir. 1993); *Burkey v. Government Employees Health Association*, 983 F.2d 656 (5th Cir. 1993); *Hayes v. Prudential Insurance Co.*, 819 F.2d 921 (9th Cir. 1989).

However, the Third Circuit ruled that the FEHBA did not create complete preemption over an FEHBA claim dispute because "FEHBA does not create a cause of action vindicating a beneficiary's interest in recovering his or her benefits under a plan." *Goepel v. Mail Handlers Benefit Plan*, 36 F.3d 306, 312 (3rd Cir. 1994). The court based its conclusion on the facts that the FEHBA's federal jurisdiction provision, 5 U.S.C. § 8912, quoted below, is limited to actions against the United States and OPM's regulations at the time "expressly provided that '[a]n action to recover on a claim for health benefits should be

brought against the carrier of the health benefits plan.' *See* 5 C.F.R. § 890.107." *Id.*[4]

In 1995, OPM filled this gap when modified its FEHBA regulations at 5 C.F.R. Part 890 and 48 C.F.R. Ch. 16 to expressly require employees to exhaust their available administrative remedy and bring any benefit claim lawsuit against OPM, rather than the carrier, under the Administrative Procedure Act, 5 U.S.C. § 701 *et seq.*, and the FEHBA, *id.* § 8912:

> The district courts of the United States have original jurisdiction, concurrent with United States Court of Federal Claims, of a civil action or claim against the United States founded on this chapter.

OPM explained in its regulatory preamble that

> Historically, OPM has required that covered individuals who want to bring suit because an FEHB carrier has denied their claim for health benefits must sue the carrier, not OPM. These interim regulations provide that legal actions arising out of a denial of FEHB benefits should be brought against OPM rather than the FEHB carrier that made the initial denial decision. * * *

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[4] In contrast, OPM's regulations consistently have required that legal actions over enrollment disputes be brought against the employing agency. 5 C.F.R. § 890.107(a).

The legislative history of § 8902(j), title 5, United States Code, shows that Congress intended OPM (at that time the Civil Service Commission) to provide an administrative appeal process, binding upon the carriers, that would save covered individuals the expense and delay of being forced into the courts to recover on meritorious claims for benefits. Based upon this directive and its central role in the administration of the FEHB Program, OPM established a detailed administrative review process for benefits claims leading to a final decision on such claims by OPM. It is OPM's requirement that this administrative review process must be followed before legal action is pursued in the courts. Further, the matter to be reviewed by a court upon appeal is the OPM decision affirming the carrier's denial of benefits, with the court's review being limited to an examination of OPM's administrative decision to deny the claim for payment or services.

Health insurance contracts under the FEHB Program are Federal contracts under 5 U.S.C., chapter 89. Accordingly, legal actions concerning disputes arising or relating to those contracts are controlled by Federal, rather than State law. Congress, in the FEHB Act, mandated Federal uniformity for all matters that relate to (1) the nature or extent of coverage; (2) benefits; and (3) payment of benefits under the FEHB Program. By statute, all health insurance contracts require the carrier to agree to pay or provide a health

> service or supply in an individual case if OPM finds that the covered individual is entitled to the benefit under the terms of the contract. Congress also directed OPM to take a central role in determining whether a health service or supply should be provided in individual cases to covered individuals and, if it should be provided, to require carriers to pay for such health service or supply. These interim regulations reaffirm the principle of uniformity in the FEHB Program by providing that in judicial disputes regarding the denial of a health benefits claim, review is to be limited to the record that was before OPM and that was the basis of the OPM decision to disallow the benefit.

60 Fed. Reg. 16,037, 16,057 (March 29, 1995). The same principles apply to the resolution of FEHBA enrollment disputes under OPM's regulations, 5 C.F.R. §§ 890.104, 890.107(a). Moreover, OPM's views expressed in the notice and comment rulemaking process are entitled to deference. *See United States v. Mead Corp.*, 533 U.S. 218, 229-30 (2001).

Soon thereafter, a federal district court recognized that this regulatory action cured the federal jurisdiction defect that the Third Circuit had identified in the *Goepel* case. This court held that the FEHBA created complete preemption over benefit claim disputes. *Hanson v. Blue Cross and Blue Shield of Iowa*, 953 F. Supp. 270, 275-76 & n. 4 (N.D. Iowa 1996). However, another federal district court reached the opposite result because the

FEHBA, 5 U.S.C. § 8902(m)(1) at the time required courts to determine as a threshold matter whether the state law was in conflict with the FEHBA health plan contract. *Arnold v. Blue Cross and Blue Shield of Texas*, 973 F. Supp. 726, 731-32 (S.D. Tex. 1997).

In 1998, Congress resolved this issue when it clarified 5 U.S.C. § 8902(m)(1) by deleting that final clause which predicated FEHBA preemption upon a conflict with state law. As now codified, FEHBA provides that

> The terms of any contract under this chapter [5 U.S.C. § 8901 et seq.] which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans. 5 U.S.C. § 8902(m)(1).

The House Report accompanying the bill explained that Congress intended the amendment

> to broaden the preemption provisions in current law, [and] to strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they live. This change will strengthen the case for trying FEHB program claim disputes in Federal courts rather than State courts.

H.R. Rep. No. 105-374, at 9 (1997); *see also* S. Rep. No. 105-257, at 9 (1998) Additionally, Representatives Elijah Cummings and John Mica

pointed out on the House floor that, with the goal of ensuring uniform provision of benefits to federal employees across the country, the amendment would fortify FEHBA's preemptive effect over local and state law. 144 Cong. Rec. H9354 (daily ed. Oct. 5, 1998). In sum,

> This amendment confirm[ed] the intent of Congress (1) that FEHB program contract terms which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) completely displace State or local law relating to health insurance or plans

H.R. Rep. No 105-374, *supra*, at 16.

This history is intended to document and highlight for the Court the efforts undertaken by the legislative and executive branches to place the FEHB Program cases, such as the instant case, in the same posture as cases under the Labor Management Relations Act, 29 U.S.C. § 185, and the Employee Retirement Income Security Act, 29 U.S.C. § 1132, as construed by this Court in the *Avco Corp. v. Machinists*, 390 U.S. 557 (1968) and *Metropolitan Life Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987), cases.

Not surprisingly, therefore, in the wake of this FEHBA amendment, the Ninth Circuit and several lower federal courts concluded that the FEHBA created federal jurisdiction sufficient to remove FEHBA claim disputes from state to federal court under the complete preemption doctrine. *See*

Botsford v. Blue Cross and Blue Shield of Montana, 314 F.3d 390 (9th Cir. 2003): *Doyle v. Blue Cross Blue Shield of Illinois*, 149 F. Supp. 2d 437, 432-33 (N.D. Ill. 2001); *Rievley ex rel. Rievley v. Blue Cross Blue Shield of Tenn.*, 69 F. Supp. 2d 1028, 1033-34 (E.D.Tenn.1999); *Carter v. Blue Cross and Blue Shield of Florida*, 61 F. Supp. 2d 1237, 1240-41 (N.D. Fla. 1999); *Kight v. Kaiser Foundation Health Plan*, 34 F. Supp. 2d 334, 339 (E.D. Va. 1999).

In *Botsford*, the plaintiff, who like Respondent Juli Pollitt, was enrolled in the government wide service benefit plan, sued the carrier on various state law theories over a FEHBA claim dispute. 314 F.3d at 391. In its *Botsford* opinion, the Ninth Circuit reasoned that

> We conclude that Congress intended to limit the defendant in suits involving disputes over FEHBA benefits to the United States. Allowing suits against carriers would undermine the federal scheme in two ways. First, it would interfere with the uniform administration of FEHBA plans because it would create an alternative mechanism for enforcing FEHBA-created rights. This would weaken OPM's authority to interpret FEHBA and its own contracts and would create a patchwork of state regulations overlaying federal FEHBA contracts. Second, allowing suits against carriers in state court would inevitably drive up the cost of FEHBA health insurance by increasing carriers' costs. This is particularly true when, as in this case, state law allows for more extensive monetary

damages than does FEHBA.

* * *

> In light of the facts that FEHBA involves only one employer, the United States, and the United States contracts with a multiplicity of carriers and has millions of employees, imposing a uniform administrative scheme makes sense. Administering the many contracts between OPM and carriers uniformly, and resolving disputes over benefits in a procedurally regular manner, simplifies FEHBA administration. This, in turn, furthers the congressional goals of uniform administration and cost-savings underlying FEHBA. Requiring beneficiaries to exhaust administrative remedies before proceeding to court, and then to sue the agency that conducted the administrative actions, reinforces the importance and increases the efficiency of the administrative scheme.

314 F.3d at 397-98.

In 2006, this Court issued its opinion in *Empire Healthchoice Assurance, Inc. v. McVeigh*, 547 U.S. 677. This case raised the issue of whether federal removal jurisdiction existed over a case in which an FEHB plan carrier sought to enforce an FEHBA contract provision concerning reimbursement and subrogation rights against a plan enrollee. The Court found that federal removal jurisdiction was lacking because regardless of whether the FEHBA, 5

U.S.C. § 8902(m)(1) preempted state laws that otherwise would govern FEHB plan subrogation and reimbursement rights, the FEHBA, *id.* § 8912, did not provide any federal court jurisdiction over those cases. This Court reasoned in pertinent part that

> FEHBA's jurisdictional provision, 5 U. S. C. § 8912, opens the federal district-court door to civil actions "against the United States." * * * OPM's regulation, 5 CFR § 890.107(c) (2005), instructs enrollees who seek to challenge benefit denials to proceed in court against OPM "and not against the carrier or carrier's subcontractors." *See supra*, at 6. Read together, these prescriptions "ensur[e] that suits brought by beneficiaries for denial of benefits will land in federal court." 396 F. 3d, at 145, n. 7.

547 U.S. at 696 (closing quotation is drawn from *Empire Healthchoice Assurance, Inc. v. McVeigh*, 396 F.3d 136, 145 n. 7 (2d Cir. 2005)). Amici ask the Court to apply this sound reasoning to this case.

3. The Instant Case

In this case, the Respondent Juli Pollitt was enrolled in the government wide service benefit plan, the Blue Cross Blue Shield Federal Employees Program ("FEP"). *See* J.A. 96-97, 124. At the government's direction, Petitioner retroactively changed Respondent's FEP enrollment from self and family to self only. J.A. 97. Petitioner thereupon sought to recover benefits erroneously paid on behalf of Respondent's minor child. J.A. 128-129. The

OPM contract establishing Respondent's FEHB plan expressly obligated Petitioner to take these actions. J.A. 40.

Flouting OPM's governing regulations, discussed above, Respondent, joined by the minor child's father, Respondent Michael Nash, filed a lawsuit in Illinois state court against Petitioner challenging the enrollment change and retroactive benefit denials. *See* J.A. 77-82. Respondent also asserted claims under state-law theories of bad-faith conduct by insurers. *Id.* 79.

While the case was pending in state court, Petitioner was informed by Ms. Pollitt's employing agency that the original direction had been in error. *See id.* at 97, 102-103. Petitioner then expeditiously corrected the enrollment action and retroactive benefit decisions. *See id.* at 84. Respondents nevertheless continue to pursue their case.

Petitioner timely removed the Respondents' case from State to Federal court. Respondents did not move to remand the case to State court. The district court upon Petitioner's motion to dismiss the original complaint allowed the Respondents an opportunity to amend their pleading. Pet. App. 10a. The second amended pleading challenged Petitioner's retroactive benefit denials and sought $1.8 million in compensatory and punitive damages for insurer bad faith under state law. *See* J.A. 132

The district court dismissed the second amended complaint on the grounds that the Respondents' remedies are exclusively federal and that under

OPM's rules Ms. Pollitt was obligated first to exhaust her available administrative remedy and then to bring suit against OPM, not the Petitioner. Pet. App. 8a.

On appeal, the U.S. Court of Appeals for the Seventh Circuit vacated the district court's decision and remanded the case to that court. The Court of Appeals erroneously found a lack of federal removal jurisdiction. In a brief, fatally flawed analysis, it reasoned as follows:

> "Complete preemption" is not a defense; instead it represents a conclusion that all claims on the topic arise under federal law, so that 28 U.S.C. § 1441 permits removal. But *Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677 (2006), holds that federal law does not completely occupy the field of health-insurance coverage for federal workers. *Empire HealthChoice* shows that the district court erred in allowing removal under § 1441 and dismissing the suit as completely preempted.

Pet. App. 3a. The Court further concluded, in error, that removal under 28 U.S.C. § 1442(a)(1), the federal officer removal provision, would only be appropriate if Petitioner had been implementing a direct order of the federal government as opposed to acting under its supervision. *Id.*

4. The Case was Removable to Federal court based on the Complete Preemption Doctrine.

Respondents' causes of action go to the very heart of an employee benefits program – enrollment and benefit decisions. This particular employee benefits program, the FEHB Program, was established for federal employees by Congress acting on behalf of their employer, the federal government. Under the U.S. Constitution, Congress has the exclusive authority of setting and adjusting federal compensation.

The enrollment and benefit decisions made by Petitioner were subject to OPM review under its governing regulations. Those regulations further state that any OPM decision must be challenged in federal court under the Administrative Procedure Act. The FEHBA, 5 U.S.C. § 8912, creates federal court jurisdiction to those cases against the United States. *See Muratore v. OPM*, 222 F.2d 918, 920 (11th Cir. 2000): "We review OPM's actions pursuant to the FEHBA under the Administrative Procedure Act."

Beneficial National Bank v. Anderson, 539 U.S. 1 (2003) is this Court's leading decision on the law of complete preemption. In that case, the Court held that the National Bank Act completely preempts state law usury claims. In so holding, the Court stated that the test for complete preemption is whether federal law "provide[s] the exclusive cause of action for the claim asserted" (*id.* at 8), not for any conceivable state law claim as the Court of Appeals erroneously ruled. *Accord*, *id.* at 9 ("[T]he dispositive

question in this case [is]: Does the National Bank Act provide the exclusive cause of action for usury claims against national banks?"); *id.* at 9 n.5 ("the proper inquiry focuses on whether Congress intended the federal cause of action to be exclusive"); *id.* at 11 ("Because §§ 85 and 86 [of the National Bank Act] provide the exclusive cause of action for such claims, there is, in short, no such thing as a state-law claim of usury against a national bank."). Unquestionably, as the Court recognized in its *McVeigh* opinion, the FEHBA and OPM's implementing regulations provide the exclusive cause of action for Respondent's erroneous FEHB plan enrollment and benefit decision claims.

We are aware that this Court has extended the complete preemption doctrine only to a limited number of circumstances in addition to National Bank Act regulated usury cases. In the Court' first opinion, on the doctrine, the Court applied complete preemption to the LMRA, 29 U.S.C. § 185. *Avco Corp. v. Machinists*, 390 U.S. 557 (1968). Subsequently, the Court applied the doctrine to ERISA, 29 U.S.C. § 1132. *Metropolitan Life Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987), cases. In the *Metropolitan Life* and *Beneficial Finance* opinions, this Court noted the close relationship between the jurisdiction provisions in the LMRA and ERISA, thereby indicating that the statutes should be read *in pari materia*. *See* 539 U.S. at 7-8; 481 U.S. at 64-66. FEHBA's jurisdictional provision is necessarily narrower than the LMRA or ERISA provisions because it carves out an exception from the sovereign immunity doctrine.

See Bryan v. Office of Personnel Management, 165 F.3d 1315, 1318 (10th Cir. 1999):

> Congress clearly intended a limited waiver of sovereign immunity in [Federal Employees Health] Benefits Act disputes – courts only have jurisdiction to review final [OPM] actions, after exhaustion, and only one remedy is available.

As the Ninth Circuit recognized in *Botsford*:

> When considered in the context of the entire statute and its purposes, however, it is clear that FEHBA's jurisdictional statement is as broad as it can be. Thus, the jurisdictional statement ultimately weighs in favor of displacement.

314 F.3d at 397. Indeed, it is entirely logical to conclude that ERISA and FEHBA cases involving enrollment or benefit claim disputes should be treated alike. Cases involving the United States and its employee benefit interests must be heard in federal court.[5]

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[5] In *Cedars Sinai Medical Center v. National League of Postmasters*, 497 F.3d 972 (9th Cir. 2007), the Court recognized that OPM's administrative remedies are binding on enrollees, such as Respondent. *Id.* at 976. However, the court held that those remedies are not applicable to a health care provider (absent receipt of authorization from the enrollee) and therefore a provider lawsuit against an FEHBA plan did not fall within the complete preemption doctrine.

Nor can Respondents escape FEHBA's exclusively federal remedies, and thus complete preemption, by casting their allegations as an insurer bad faith claim, as they did in part in the original complaint and then in the second amended complaint. In *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), the Court held that ERISA's remedy for denials of benefits completely preempted state tort claims that derived from the benefits denials. In language also applicable to this case, the Court said: "[D]istinguishing between pre-empted and non-pre-empted claims based on the particular label affixed to them would 'elevate form over substance and allow parties to evade' the pre-emptive scope of [the federal statute] . . . simply 'by relabeling their contract claims as claims for tortious breach of contract.'" *Id.* at 214 (quoting *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 211 (1985)); *accord, Burkey v. Gov't Employees Hosp. Ass'n*, 983 F.2d at 660; *Hayes v. Prudential Insurance Co.*, 819 F.2d at 925 (same, in FEHBA context).

Based on this Court's interpretation of the FEHBA in *McVeigh*, the Court of Appeals ruling should be reversed, and federal removal jurisdiction over this case should be sustained. Affirmation of the Court of Appeals ruling would upend OPM's comprehensive regulatory scheme and open the floodgates to enrollment and benefits claims litigation in blatant contravention of Congressional intent that the FEHB Program should be administered in a nationally uniform manner.

Application of state law based causes of action to FEHB plan enrollment and benefit disputes would

frustrate the specific objectives of the FEHBA in general and 5 U.S.C. § 8902(m)(1) in particular. Achievement of the federal policy underlying the FEHBA requires a nationally uniform program of health benefits for federal employees that is administered on a nationally uniform basis. It further requires that enrollment and benefit claim disputes be heard and resolved exclusively in federal court.

5. The Case was Removable to Federal court based on the Federal Officer Removal Statute.

The federal officer removal statute permits removal of an action against "any officer (*or any person acting under that officer*) of the United States or of any agency thereof," 28 U. S. C. § 1442(a)(1) (emphasis added). There are three established requirements for removal under this section by a party, such as Petitioner, who is not a federal officer: (1) the removing party must have been acting under a federal officer; (2) the acts underlying the complaint were performed in the course of the removing party's responsibilities, and (3) a colorable federal defense exists. *See Willingham v. Morgan*, 395 U.S. 402 (1969).

Given the close relationship between FEHBA contractors and the government on a matter critical to the government's day-to-day operations, as discussed above, it is clear that Petitioner was acting under a federal officer. The second "triggering" requirement is met because the Respondent's claims arose in the context of Petitioner "fulfill[ing] the terms of a contractual agreement." *Watson*, 551 U.S.

at 153; *see also Maryland v. Soper*, 270 U.S. 9, 33 (1926) (the federal officer removal statute "does not require that the prosecution must be for the very acts which the officer admits to have been done by him under federal authority"). Finally, we have demonstrated that the Petitioner has colorable defenses under the FEHBA, specifically that the exclusive OPM disputed claim procedure, discussed above, required Ms. Pollitt to exhaust her available administrative remedies under 5 C.F.R. §§ 890.104, 890.105, and bring any lawsuit against her employing agency with respect to the enrollment issue and against OPM with respect to the benefit issues, 5 U.S.C. § 8912; 5 C.F.R. 890.107. Furthermore, if the FEHBA's general state law preemption provision is to be accorded any meaning, as it must under this Court's jurisprudence (*see Cooper Industries, Inc. v. Aviall Services, Inc.*, 543 U.S. 157, 158 (2004), then it must be recognized to preempt state law tort claims such as those asserted by Respondents that are inextricably intertwined with the enrollment and benefit issues. Federal courts have recognized this core principle for over twenty years. *See, e.g., Hayes v. Prudential*, 819 F.2d at 925.

FEHB participants and the overall FEHB program objectives are best served by a nationally uniform, comprehensive, and efficient process for handling benefit determinations, rather than submitting such decisions to a complex variety of state administrative and judicial processes, just as Congress and OPM have intended. *See Egelhoff v. Egelhoff*, 532 U.S. 141 (2001)(same in ERISA context).

CONCLUSION

For all of the foregoing reasons, *amici* respectfully request that the Court reverse the decision of the U.S. Court of Appeals for the Seventh Circuit under review.

Respectfully submitted,

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December 18, 2009